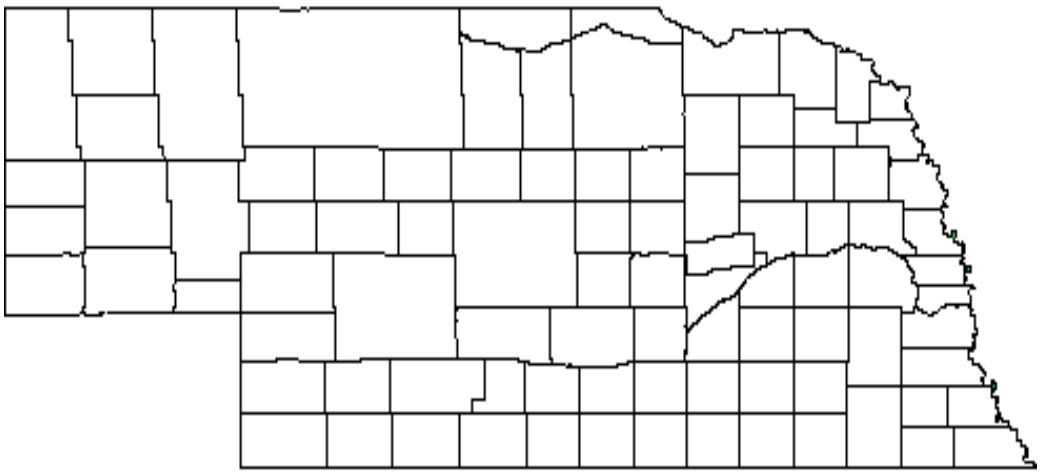
Nebraska
HIV/AIDS Housing Plan



Prepared for:

Nebraska Department of Health and Human Services

Prepared by:

AIDS Housing of Washington

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Prepared for and funded in part by:

Nebraska Department of Health and Human Services
HIV Prevention and Ryan White Programs
P.O. Box 95044
Lincoln, Nebraska 68509

(402) 471-9098

Prepared by:

AIDS Housing of Washington
2014 East Madison, Suite 200
Seattle, Washington 98122

(206) 322-9444
www.aidshousing.org
info@aidshousing.org

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Steering Committee Meeting Attendees

The following individuals participated in one or more meetings of the Nebraska HIV/AIDS housing needs assessment Steering Committee. They are listed by name and agency affiliation. Their leadership and dedication were invaluable.

Becky Aboushady
Nebraska AIDS Project

Diane K. Adams
Lexington Housing Authority

Kim Anderson
South Central Behavioral Services

Nancy J. Bentley
Scotts Bluff County Housing Authority

Amanda Buscher
Nebraska AIDS Project

Jean Chicoine
Nebraska Department of Health and Human Services
Nebraska Homeless Assistance Program

Theresa Christensen
Salvation Army

Leslie Clark
Community Member

Heather Cline-Ford
Central Nebraska Community Services

Daniel Cobos
University of Nebraska Medical Center
Ryan White Title III/ADAP

Pat Compton
Nebraska Department of Economic Development

Joseph Conrad
Nebraska AIDS Project

Becky Diercks
Community Action Partnership of Mid-Nebraska

Demond Flowers
Family Housing Advisory Services

Steve French
Nebraska AIDS Project Volunteer

Steve Gable
Nebraska AIDS Project Volunteer,
NRRC, PWA, NAPWA

Dana Grisham
Community Alliance, Omaha

Barbara Hansen
Nebraska AIDS Project

Gary Henderson
Community Member

Dennis Hoffman
Centerpointe, Lincoln

Judy Hughes-Anderson
Nebraska Department of Health and Human Services

Sandra Klocke
Nebraska Department of Health and Human Services

Connie Longie
Panhandle Mental Health Center

William R. Mann
Nebraska AIDS Project Volunteer

Tom Maxson
Freedom House
South Central Behavioral Services

Betty Medinger, LCSW
Nebraska Department of Health and Human Services
Child Care, Community Service Block Grant, and
Nebraska Homeless Assistance Program

Janet Oberhauser
CPG Northern Region

Amy Ondrak
NRRC

Karen Parde
Nebraska Department of Health and Human Services
Community Service Block Grant

Paulette Pool
Hastings Housing Authority

Erin Porterfield
Nebraska AIDS Project

Mike Saklar
Siena/Francis House, Omaha

Brad Schmeichel
City of Lincoln Urban Development Department/Community Planning

Galen Sears
NRRC

Dean Settle
Community Mental Health Center of Lancaster County

T.J. Seward
Nebraska AIDS Project

Ron Snell
Lincoln Connection, North Platte

Tim Sullivan
Nebraska AIDS Project

David Traster
People's City Mission

Cindy White
NRRC

Elaine Wiseman
Kearney Housing Agency

Russell Wren
Nebraska Department of Health and Human Services Ryan White Title II

Nebraska Department of Health and Human Services

Ron Ross
Director
Nebraska Department of Health and Human Services

Dan Cillessen
Administrator
Office of Disease Prevention and Health Promotion

Sandra Klocke
Administrator
HIV Prevention and Ryan White Programs

Judy Hughes-Anderson
Financial/Data Systems Coordinator
HIV Prevention and Ryan White Programs

Russ Wren
Program Manager
Ryan White Title II Program

AIDS Housing of Washington

Elizabeth Wall
Planning and Consultations Manager

Randall Russell
Consultant

Kate Kingery
Housing Planner

Amy Davidson
Housing Planner

Erin Ficker
Planning Team Coordinator

Tawni Stetson
Planning Assistant

Key Stakeholders

The following individuals participated in meetings and interviews as part of the Nebraska HIV/AIDS housing needs assessment process. They are listed by name and agency affiliation and the list is organized by city.

The contribution of the stakeholders listed below, along with that of people living with HIV/AIDS who participated in focus groups, is gratefully acknowledged.

Columbus

Howard Smith
Columbus Housing Authority

Fremont

Sue Kleider
Fremont Housing Authority

Suzanne Smith
The Crisis Center for Domestic Abuse/Sexual Assault

Captain Abe Tamayo
The Salvation Army

Gering

Barbara Blourock, Ph.D.
Community Member

Nancy J. Bentley
Scotts Bluff County Housing Authority

Janet Soule
Panhandle Community Services
Community Health Center

Grand Island

Nancy Casarez
Behavioral Health Services
Goodwill Industries of Greater Nebraska Inc.

Heather Cline-Ford
Central Nebraska Community Services

Tom Conlon
Goodwill Industries of Greater Nebraska Inc.

Jerenne Garroutte
City of Grand Island

Cindy Preisendorf
Community Human Resource Center

Rick Ruzicka
Hall County Housing Authority

Hastings

Linda Addison
Housing Development Corporation

Tom Schick
Catholic Social Services

Kearney

Sharon Fox
Residential Assistance to Families in Transition (RAFT)

Barbara Hansen
Nebraska AIDS Project

Tom Maxson
South Central Behavioral Services

Amy Stump
Nebraska AIDS Project

Lincoln

Bernice Afuh
Lincoln–Lancaster County Health Department

Randy Archuleta
Nebraska Investment Finance Authority

Olga Caicedo
NAF Multicultural Human Development Corporation

Jean Chicoine
Nebraska Department of Health and Human Services
Nebraska Homeless Assistance Program

Lincoln (continued)

Stella Dargeloh
Nebraska Department of Correctional Services

Mike Fallesen
Nebraska Housing Finance Authority

Mary Hepburn O'Shea
O.U.R. Homes

Judy Hughes-Anderson
Nebraska Department of Health and Human Services

Lara Huskey
Nebraska Department of Economic Development
Community and Rural Development

CJ Johnson
Region 5 Systems

Sandra Klocke
Nebraska Department of Health and Human Services

Cliff Kumm
USDA Rural Development

Betty Medinger, LCSW
Nebraska Department of Health and Human Services
Child Care, Community Service Block Grant, and
Nebraska Homeless Assistance Program

Claudia Menjwor
NAF Multicultural Human Development Corporation

Caroline Negretti
DayWatch

Larry Potratz
Lincoln Housing Authority

Ron Ross
Nebraska Department of Health and Human Services

Dean Settle
Community Mental Health
Center of Lancaster County

Peg Sneller-Hamilton
Cedars Youth Services

Jeri Weberg-Bryce
Nebraska AIDS Project

Russ Wren
Nebraska Department of Health and Human Services
Ryan White Title II

Loup City

Cheryl Holcomb
Central Nebraska Community Services

Norfolk

Connie Mazoula
Temporary Housing Association (THAT)
St. Vincent De Paul

Paul McIntosh
Liberty Center Services

Sheila Miller
Norfolk Housing Authority

Judy Wilson
The Link (Men's Halfway)

North Platte

Jennifer L. Fisher
Lutheran Family Services of Nebraska, Inc.
Center for Healthy Families

Debra Morgan
North Platte Housing Authority

Rachel Stahr
NAF Multicultural Human Development Corporation

Nancy Striebel
Lincoln City Community Development Corporation

Omaha

Greg Burfitt
U.S. Department of Housing and Urban Development

Amanda Buscher
Nebraska AIDS Project

Jacqueline Cook
Charles Drew Health Center

Margie Dumas
American Red Cross
Consumer Advocate Heartland Chapter

Omaha (continued)

Elida R. Enright
Nebraska AIDS Project
Chicano Awareness Center

Demond Flowers
Family Housing Advisory Services

Patrick Ford
Nebraska Legal Services

Kristy Gill
Nebraska AIDS Project

Alex Gray
GOCA

Dana Grisham
Community Alliance, Omaha

Rosey Higgs
Nebraska AIDS Project

Juanita L. James
Omaha Housing Authority

Lucie Long
Nebraska AIDS Project

Michelle Oestmann
Nebraska AIDS Project

Ben Osborn
U.S. Department of Housing and Urban Development

Erin Porterfield
Nebraska AIDS Project

T.J. Seward
Nebraska AIDS Project

Tim Sullivan
Nebraska AIDS Project

Susan Swindells, M.B.B.S.
University of Nebraska Medical Center

Angela Tuininga
Nebraska AIDS Project

Scottsbluff

Marcia L. Estrada
Cirrus House

Barbara Jolliffe
Panhandle Substance Abuse Council

Kim Loomis
In Touch Counseling

J. Martin Vargas
Panhandle Community Services
Migrant Health Program

John McVay
Panhandle Mental Health Center

Jill Young
Nebraska AIDS Project

Wisner

Craig Malmberg
Goldenrod Hills Community Services

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Executive Summary

> "More than anything, I could handle this disease and manage my life better if I knew I had a place to call home."
>
> *Person living with HIV/AIDS in Nebraska*

Nebraska HIV/AIDS Housing Plan

The *Nebraska HIV/AIDS Housing Plan* is the culmination of a nine-month planning process that brought together a wide range of community stakeholders to consider and plan for the housing needs of Nebraskans living with HIV/AIDS and their families. Housing and services providers, people living with HIV/AIDS, and others statewide participated in the needs assessment process and provided input and feedback on the *Nebraska HIV/AIDS Housing Plan*.

Given the dynamic nature of HIV disease and other factors that affect HIV/AIDS housing planning, it is essential to regularly reassess the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs. It is intended that this plan be built upon, revised, and expanded as current objectives are met and new gaps and needs emerge.

Community Participation in the Needs Assessment Process

The Nebraska Department of Health and Human Services convened the needs assessment and planning process and invited a broad range of community stakeholders to participate. A **Steering Committee** was formed in February 2003 to oversee and guide the needs assessment and planning process. The committee was comprised of people living with HIV/AIDS and representatives from community-based organizations that provide housing and services to people with low incomes and/or special needs.

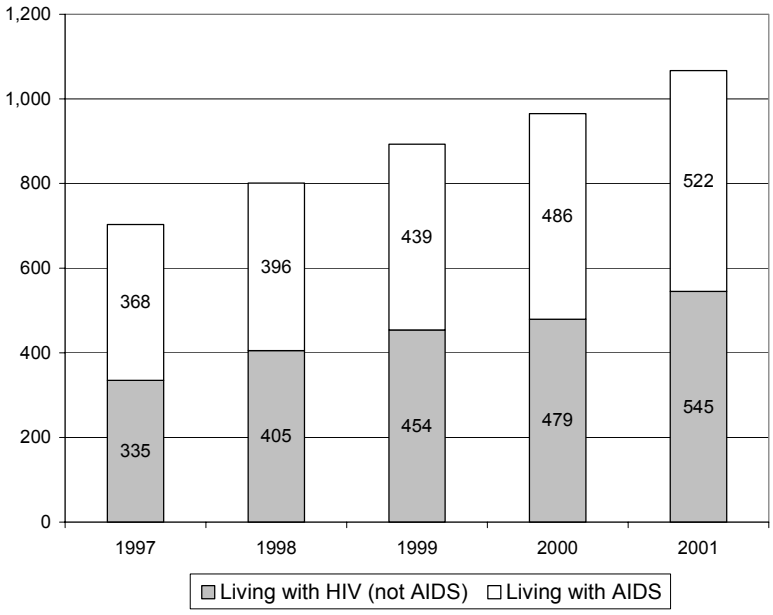
In addition to participating in Steering Committee meetings, **people living with HIV/AIDS** participated in the needs assessment process though a housing survey and consumer focus groups. In 2002, a total of 215 people living with HIV/AIDS completed a **housing survey** that posed questions about individuals' housing histories, needs, and preferences. People living with HIV/AIDS from around the state participated in **focus groups**, which allowed participants to discuss their housing situations, needs, and preferences in more detail than the survey had allowed.

Interviews were held with **key stakeholders** from throughout the state, including case managers, housing and service providers, housing developers, government representatives, clinical social workers, medical providers, and other concerned community members, including members of the Steering Committee. These stakeholders were identified as those most knowledgeable as well as able to provide leadership in the future on related issues.

The Context of HIV/AIDS Housing in Nebraska

Because medical advances are helping people with HIV/AIDS live longer lives, **there are now more people living with HIV/AIDS**—who are potentially in need of related assistance—than ever before.

At the end of 2002, a total of 1,112 Nebraskans were living with HIV/AIDS, including 557 people living with AIDS and another 555 people living with HIV who had not been diagnosed with AIDS.



People of color are disproportionately impacted by HIV/AIDS in Nebraska, particularly African Americans. Compared to just 6 percent of the state's population, almost one-quarter (24 percent) of those living with HIV/AIDS are African Americans.

Increasingly, younger people are affected by HIV/AIDS. While less than one-quarter of those living with AIDS are under 30 years old, 40 percent of those living with HIV are in this age group.

People living with HIV/AIDS in Nebraska experience many of the same challenges as other Nebraskans, especially those with low incomes—difficulties finding affordable, good-quality housing, overcoming geographic barriers to access medical care, services, and employment, and limited employment opportunities in many areas.

Many people have difficulty paying housing costs. For example, in Omaha, a one-bedroom apartment at Fair Market Rent (FMR) is unaffordable to a full-time minimum wage worker. The gap between the FMR and what a person can afford to pay is $224. Key stakeholders identified the lack of safe, affordable housing units, in both rural and urban areas, as the primary barrier to finding and maintaining stable housing.

More than a quarter of those who responded to the housing survey had incomes less than $500 per month, which is below poverty level. Slightly more than one-third of respondents were "severely housing cost burdened," paying more than half of their income for housing, while just 12 percent had regular assistance paying their

Monthly SSI payment *equivalent to just 17% of the state median income*		**$552**
Percentage at which rent is affordable *according to HUD's standards*	**X**	**30%**
Available to pay for housing	**=**	**$166**

housing costs. In addition, 15 percent had faced eviction in the past year, and 39 percent had been homeless since testing positive for HIV.

Across Nebraska, many people living with HIV/AIDS continue to hide their health status in fear of the negative impact disclosure may have on their families, employment, health insurance, housing, and physical safety. This affects the willingness of people living with HIV/AIDS to reach out for support and assistance, especially people living in smaller communities, rural settings, and culturally based communities.

There are two major federal programs dedicated to serving the needs of people living with HIV/AIDS that can be used for housing. The Housing Opportunities for Persons with AIDS (HOPWA) program administered by the U.S. Department of Housing and Urban Development (HUD) is the primary source of funding dedicated to meeting the housing needs of people living with HIV/AIDS. Nebraska is not eligible to receive a formula allocation of HOPWA funds because less than 1,500 cumulative cases of AIDS have been reported statewide. However, in June 2003, the Nebraska Department of Health and Human Services partnered with the Nebraska AIDS Project and other community stakeholders to submit an application for HOPWA Competitive funds, which proposed a range of housing initiatives.

The **Nebraska AIDS Project** (NAP) is the only AIDS service organization in Nebraska. Founded in 1984, NAP provides a range of services to people living with HIV/AIDS in Nebraska, southwest Iowa, and eastern Wyoming, including case management, support groups, education and prevention, HIV counseling and testing, Nebraska AIDS Hotline, and programs for priority populations. Case management and other support services are available to people living with HIV/AIDS through five offices located in Kearney, Lincoln, Norfolk, Omaha, and Scottsbluff. The Watanabe Wellness Center is located in Omaha and provides clients access to a resource center for AIDS-related issues, mental health services, breakfasts, lunches, massage, and other complimentary therapies. In 2002, a total of 723 unduplicated clients were served through NAP programs.

Nebraska receives funding dedicated to serving people living with HIV/AIDS from the U.S. Department of Health and Human Resources and Services Administration's (HRSA) Ryan White CARE Act. Although these funds allow for the provision of many valuable services, they alone cannot and should not be the sole source of support for people living with HIV/AIDS.

Critical Issues in Housing People Living with HIV/AIDS

The Steering Committee reviewed findings from the needs assessment activities and identified the critical issues that most impact the provision of housing and services to people living with HIV/AIDS.

Stigma and Discrimination Seriously Impact Access to Housing

Throughout Nebraska, people living with HIV/AIDS and their families, service providers, and the general community are impacted by fear, stigma, and discrimination related to HIV and a lack of accurate knowledge about the disease. These issues can directly impact access to housing and feelings of housing stability. They were raised in every consumer focus group and most key stakeholder interviews. Many survey respondents and focus group participants feared losing their

housing if they disclosed their HIV status to their landlord or mortgage holder. People living with HIV/AIDS and service providers related incidents of violence and discrimination experienced by people simply because they were living with HIV/AIDS. Steering Committee members identified five specific issues that are related to this topic:

- People living with HIV/AIDS in Nebraska are impacted significantly by **HIV-related stigma**. The fear of being stigmatized affects individuals' willingness to access needed services.
- There is a lack of understanding on the part of some service providers of the need for and importance of **confidentiality** related to HIV and the impact that fear of disclosure has on the willingness of people living with HIV/AIDS to access services for which they may be eligible.

> "Stigma is a thousand-pound gorilla that most of us carry around, even providers."
>
> *Key Stakeholder*

- **Fear of HIV/AIDS** on the part of service providers and community members impacts the ability of people living with the disease to access jobs, housing, and services.
- The **lack of community education** about HIV/AIDS impacts the acceptance of people living with the disease.
- Gay, lesbian, bisexual, and transgender Nebraskans experience stigma and discrimination based on their **sexual orientation**, regardless of their HIV status. As a result, Nebraskans living with HIV disease who are or are perceived to be gay, lesbian, bisexual, or transgender may experience heightened stigma and discrimination.

Lack of Appropriate Affordable Housing Options

More than one-third of people who completed the housing survey were at risk of homelessness because of their housing cost burden. The lack of appropriate affordable housing is clearly a very significant issue in Nebraska and is the primary housing barrier for all people with low incomes, including those living with HIV/AIDS. People living with HIV/AIDS and key stakeholders who participated in the needs assessment identified challenges in locating housing that was of a decent quality, convenient, and affordable to consumers given their incomes. More than a quarter had accessed financial assistance in the past to prevent homelessness. Steering Committee members identified four specific issues that are related to this topic:

- There is a **lack of affordable, safe, decent, and appropriate housing** that limits access to the full continuum of housing options for people living with HIV/AIDS.
- There is **limited funding** available to support the creation and maintenance of needed programs.
- Housing providers and HIV/AIDS service providers need to increase **collaboration**.
- People living with HIV/AIDS and service providers need **more information** about and awareness of available housing options.

Access to and Availability of All Necessary Support Services

Access to appropriate services supports housing stability. Housing alone will not ensure health, stability, and quality of life for people living with HIV/AIDS without access to a range of medical and support services. The affordability of available resources is also an important consideration. For example, an individual who is eligible for assistance through the Medicaid program may not be able

to afford the required co-pay for prescriptions. Steering Committee members identified six specific issues that are related to this topic:

- The housing and related service needs of people living with HIV/AIDS have **changed and expanded** as people are living longer with the disease.
- It is challenging to meet the needs of **an increasingly diverse population** of people living with HIV/AIDS. Specific barriers to accessing services included: language, cultural differences based on race and ethnicity, and the lack of cultural diversity among providers of HIV-related services.
- Not all clients understand **the role of case managers** and that through accessing case management support their needs are more likely to be anticipated and met to avoid crisis.
- **Linkages** between housing and all necessary support services are lacking for many people living with HIV/AIDS, including both those in need of housing and those who are housed.
- There is a **lack of transportation options** for people in both urban and rural areas of the state.
- A lack of **medical, dental, and case management services** to adequately address the global needs of persons living with HIV/AIDS was identified.

Financial Issues for People Living with HIV/AIDS

Many people living with HIV/AIDS survive on very limited incomes and struggle to meet their daily financial obligations. More than a quarter of survey respondents reported incomes well below the poverty level. Steering Committee members identified three specific issues that are related to this topic:

> "You can sleep in your car, but you can't drive your house."
>
> *Person living with HIV/AIDS in Nebraska*

- Due to the physical challenges faced by people living with HIV/AIDS and the inability of many to maintain employment, **poverty** is a significant barrier to obtaining and maintaining adequate housing and accessing needed services and information.
- Some people living with HIV/AIDS have high medical expenses, which impacts their financial situation and credit rating and subsequently **limits their access** to certain housing options.
- People living with HIV/AIDS and service providers need **more information about and awareness of** training and employment opportunities available to disabled persons.

Recommendations and Strategies Developed to Meet Need

Initially, responsibility to implement the plan's recommendations will rest with the Nebraska Department of Health and Human Services and the Nebraska AIDS Project, as the two agencies that historically have taken the lead on HIV/AIDS housing issues in Nebraska. The goal is that leadership will continue to emerge from a broader group of community stakeholders in order to make the best use of existing expertise and resources. The implementation of each recommendation will require the collaboration of a range of stakeholders and more detailed action planning. Ultimate leadership will hopefully come to rest in a collaboration of housing and support service experts and/or agencies.

Stigma and Discrimination Seriously Impact Access to Housing

The following strategies were developed to address the critical issues related to stigma and discrimination:

1. Educate community stakeholders about HIV disease and the impact of HIV/AIDS in Nebraska in order to increase awareness and acceptance of people living with HIV/AIDS and to dispel myths about HIV/AIDS and Nebraskans who live with the disease.
   - Community stakeholders to be targeted for education efforts include: the general public and community groups; policy makers and politicians; housing authorities, property managers, and landlords; support service providers, including health-care providers and employment/job training programs; and populations living with and at risk for the disease.
   - Strategies that will support education include the following:
     - Humanize people living with the disease through the sharing of personal stories and experiences. Clearly articulate the range of people affected by HIV (race, age, class, sexual orientation, etc.). Make information available through public service announcements, Web sites, public speaking, etc.
     - Build on existing relationships to increase awareness and support. For example, engage a knowledgeable and benevolent landlord, service provider, pastor, or other community member in community education efforts.
     - Support state and local leaders who include people living with HIV/AIDS, as appropriate, in their public comments, and work to increase public support for such inclusion.
     - Continue and enhance existing HIV prevention efforts. Continue to engage faith-based organizations in these efforts.

2. Increase housing stability and access to housing resources for people living with HIV/AIDS by educating them about fair housing laws and the standard operating procedures of housing authorities as they relate to confidentiality and the disclosure of disability status. Explore and develop strategies to ensure people living with HIV/AIDS have the information they need about their housing rights in order to avoid experiences of discrimination in housing.

Lack of Appropriate Affordable Housing Options

In order to address the critical issues related to the lack of affordable housing, the following strategies were developed:

1. Increase affordable housing units accessible to people living with HIV/AIDS. Strategies that will support increased access include the following:
   - Develop and enhance partnerships between HIV/AIDS service providers and affordable and special needs housing providers.
   - Ensure the needs of people living with HIV/AIDS are represented in housing and service planning processes, including local Continuum of Care planning for homeless services and Consolidated Plan processes.

- Apply for all additional federal, state, local, and private resources that will support the implementation of affordable housing strategies identified in the plan or subsequently developed to address emerging need.
- Advocate to governmental entities at the federal, state, and local levels for political support and funding for affordable housing development.

2. Increase opportunities for emergency housing solutions generally, and improve access to assistance for persons living with HIV/AIDS. Strategies that will support improved access include the following:
   - Increase linkages between AIDS service providers and emergency assistance programs.
   - Educate people living with HIV/AIDS about existing programs.
   - Develop additional target resources, if needed.

3. Increase housing stability and access to housing resources for people living with HIV/AIDS through education. Support success in housing by providing education and training about:
   - Available housing options and opportunities and how to access them
   - Tenant rights and responsibilities and fair housing laws
   - Housing search strategies
   - Life-skills development
   - Money management, budgeting, and credit repair
   - Housing readiness
   - Relapse-prevention strategies

4. Develop a comprehensive listing of HIV/AIDS services available in Nebraska, including eligibility criteria and contact information. Increase awareness of programs and guidelines by widely distributing this listing to housing and service providers throughout the state. Make the material available in forms and locations such that people could access relevant information without disclosing their HIV status.

Access to and Availability of All Necessary Support Services

The following strategies were developed to address the critical issues related to access to and the availability of all necessary support services:

1. Educate people living with HIV/AIDS about the services available both through the HIV/AIDS service system and the other service systems in the state.

2. Advocate for additional case management services for people living with HIV/AIDS in order to increase the support available to each client through this system.

3. Explore opportunities to develop a comprehensive peer-to-peer mentoring program to assist people living with HIV/AIDS to access housing and services and to provide peer support to those living with the disease.

4. Increase resources available to people living with HIV/AIDS who have mental health and/or substance use issues by maintaining and enhancing linkages between AIDS service providers and mental health and substance use treatment providers.

5. Increase access to appropriate services for people who are monolingual (in a language other than English) by ensuring the availability of translated materials and access to translators. Increase volunteerism among people who are bilingual. Maintain and enhance linkages between AIDS service providers and agencies currently serving monolingual populations.

6. Develop additional transportation options in order to increase access to medical and support services for people living with HIV/AIDS.

7. Increase the availability of support services to people living in rural areas of the state.

Financial Issues for People Living with HIV/AIDS

The following strategy was developed to address the critical issues related to financial issues for people living with HIV/AIDS:

1. Enhance economic opportunities for persons living with HIV/AIDS to support housing stability. Develop and enhance linkages between AIDS service providers and employment and job training programs in Nebraska, including Vocational Rehabilitation, Workforce Development, and the Ticket-to-Work program.

Ongoing and Future Plan Implementation

The Nebraska HIV/AIDS housing needs assessment and planning process increased connections among people across the state and provided a deeper understanding of the housing needs of people living with HIV/AIDS. The *Nebraska HIV/AIDS Housing Plan* includes implementation principles and preliminary action steps that represent but one of the next steps in this ongoing process. The implementation of effective initiatives and programs relies on increased community knowledge, successful partnerships, and continued assessment and planning. The stakeholders involved in this process have an ongoing commitment to addressing all the identified needs through further action planning, increased collaboration and partnerships, and securing new sources of funding to support programs.

The research, development, and publication of this plan was funded in part by the Housing Opportunities for Persons with AIDS (HOPWA) National Technical Assistance Program in partnership with the U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing.

Introduction

> "More than anything, I could handle this disease and manage my life better if I knew I had a place to call home."
>
> *Person living with HIV/AIDS in Nebraska*

Nebraska HIV/AIDS Housing Plan

The *Nebraska HIV/AIDS Housing Plan* is the culmination of a nine-month planning process that brought together a wide range of community stakeholders to consider and plan for the housing needs of Nebraskans living with HIV/AIDS and their families. Housing and services providers, people living with HIV/AIDS, and others from around the state participated in the needs assessment process and provided input and feedback on the plan document.

Given the dynamic nature of HIV disease and other factors that affect HIV/AIDS housing planning, it is essential to regularly reassess the needs of people living with HIV/AIDS and the most appropriate strategies to meet those needs. It is intended that this plan be built upon, revised, and expanded as current objectives are met and new gaps and needs emerge.

Background

In late 2001, Nebraska Department of Health and Human Services (NEHHS) determined that better information was needed about the housing needs of people living with HIV/AIDS in Nebraska. The agency initiated a process of information gathering that included a survey of people living with HIV/AIDS about their housing histories, needs, and preferences and a series of key stakeholder meetings. These meetings provided a forum for both education about relevant HIV/AIDS and housing issues and input from a broad range of informed community members.

The education and assessment effort led community stakeholders to develop an application for funding under the U.S. Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS (HOPWA) Competitive Program. While that application was not submitted, community advocacy and agency leadership led NEHHS to allocate funding for this comprehensive statewide HIV/AIDS housing needs assessment, initiated in early 2003, and to commit to the development and submission of a HOPWA Competitive application during the next funding cycle. Nebraska HHSS contracted with AIDS Housing of Washington (AHW) to facilitate the needs assessment and planning process.

AIDS Housing of Washington (AHW), a nonprofit corporation located in Seattle, Washington, has developed more than 140 units of housing for people living with HIV/AIDS since its founding in 1988. AHW also provides information, planning assistance, consultations, and training in communities nationwide, and has worked in more than thirty regions to develop comprehensive HIV/AIDS housing plans. AHW's goal is to help stabilize the lives of individuals and families through improving access to affordable housing and appropriate support services. AHW's work on the *Nebraska HIV/AIDS*

Housing Plan was funded in part by the U.S. Department of Housing and Urban Development's National HOPWA Technical Assistance Program.

Community-Based Needs Assessment and Planning Process

Interested community members, including people living with HIV/AIDS, representatives of AIDS service organizations, housing developers and providers, members of local government agencies, advocates, medical providers, and others participated in this needs assessment and planning effort. Findings from the needs assessment will inform community planning and agency program development. The community-based planning process included a number of key components, which are outlined here.

Steering Committee: A Steering Committee was formed in February 2003 to oversee and guide the needs assessment and planning process. The committee was comprised of people living with HIV/AIDS and representatives from community-based organizations that provide housing and services to low-income people, including those living with HIV/AIDS, mental illness, and substance use issues, and those who are homeless. Members of the Steering Committee reviewed background information and other written data related to HIV/AIDS, housing affordability, homelessness, and dedicated resources; identified critical issues; developed recommendations and action steps; and approved the final plan. Steering Committee members are listed with their affiliations at the beginning of the plan. Minutes from each Steering Committee meeting can be found in ***Appendix I***.

Key stakeholder interviews: Key stakeholder interviews were held with 76 people identified by Steering Committee members and other involved stakeholders. Group and individual interviews were conducted with case managers, housing and service providers, housing developers, government representatives, clinical social workers, and other concerned community members, including members of the Steering Committee.[1] These stakeholders were identified as those most knowledgeable as well as able to provide leadership in the future on related issues. Issues identified by key stakeholders were summarized by AHW and are presented in a chapter of the plan.

Housing survey: In 2002, a total of 215 people living with HIV/AIDS completed a housing survey that addressed individuals' housing histories, needs, and preferences. Completed surveys were received from residents of at least 25 counties in Nebraska. AHW analyzed and summarized the survey results, which are presented in a chapter of the plan. Complete survey data appears in ***Appendix III***.

Consumer focus groups: Consumers were also included in the needs assessment process through focus groups. These allowed for more qualitative and broader-ranging information than the survey. A total of 38 people living with HIV/AIDS participated in focus groups held in Lincoln, Norfolk, North Platte, Kearney, Omaha, and Scottsbluff. Meetings were organized by the Nebraska AIDS Project and were facilitated by AHW. Consumer focus group summaries appear in ***Appendix V***.

Document review and summary: Data related to population demographics, housing availability and affordability, homelessness, HIV/AIDS epidemiology, and dedicated HIV/AIDS housing resources were reviewed and summarized by AHW.

[1] Please see the comprehensive list of key stakeholders and agency affiliations at the front of this plan.

Population Demographics

The demographic profile of people living with HIV/AIDS in Nebraska reflects the profile of the general population. The following pages present information about population, race and ethnicity, income, and poverty in Nebraska. Key facts include:

- The population of Nebraska in 2002 was 1,729,180.
- The state's population grew 10 percent between 1990 and 2002.
- Nebraska's residents are primarily White, with 90 percent of the total population in 2000.
- Hispanics/Latinos are the second largest racial or ethnic group in the state, with 6 percent of the population.
- The estimated Median Family Income (MFI) for the state in 2003 was $55,400.
- The MFI ranged from a high of $63,300 in the Omaha metropolitan area to $28,900 in Loup County.
- In 1999, the most recent year for which county-level data is available, 10 percent of Nebraska residents were living in poverty.

Population

In 2002, the total population of the state of Nebraska was 1,729,180 residents. Douglas County had the largest population by far of any of the counties in 2002 with 472,744 residents or 27 percent of the state's total. Cass, Douglas, Sarpy, and Washington Counties make up the Omaha metropolitan area, which was home to 646,113 (37 percent) of the state's residents in 2002. The next largest county was Lancaster County, where Lincoln is located, with 257,513 residents. The least populous county in 2002 was Arthur County, in northwestern Nebraska, with 416 residents.

The population of Nebraska increased 10 percent from 1990 to 2002. The highest rates of growth occurred in Sarpy County (26 percent), Dawson County (23 percent), Dakota County (21 percent), and Lancaster County (21 percent). Both Dawson and Dakota Counties started with fewer than 20,000 people in 1990. Meanwhile, the counties with the greatest population loss were Blaine (-22 percent), Hitchcock (-19 percent), and Boyd and Thomas (-18 percent).[2] ***Appendix II*** features a list of the 1990 and 2002 populations of every county of the state, as well as the percent change during the years between.

Race and Ethnicity

The most recent statistics available on race and ethnicity in Nebraska are from the 2000 Census. They show that the population of Nebraska is primarily White, with 90 percent of the total

[2] U.S. Census Bureau, Population Division, *Table CO-EST2002-01-31: Nebraska County Population Estimates: April 1, 2000 to July 1, 2002*, Release Date: April 17, 2003. Available online: eire.census.gov/popest/data/counties/tables/CO-EST2002/CO-EST2002-01-31.php (Accessed: August 4, 2003). U.S. Census Bureau, *(CO-99-2) County Population Estimates for July 1, 1999 and Population Change for April 1, 1990 to July 1, 1999* (includes revised April 1, 1990 population estimates base), March 9, 2000. Available online: eire.census.gov/popest/archives/county/co_99_2.php (Accessed: January 28, 2003). AIDS Housing of Washington calculated percent change.

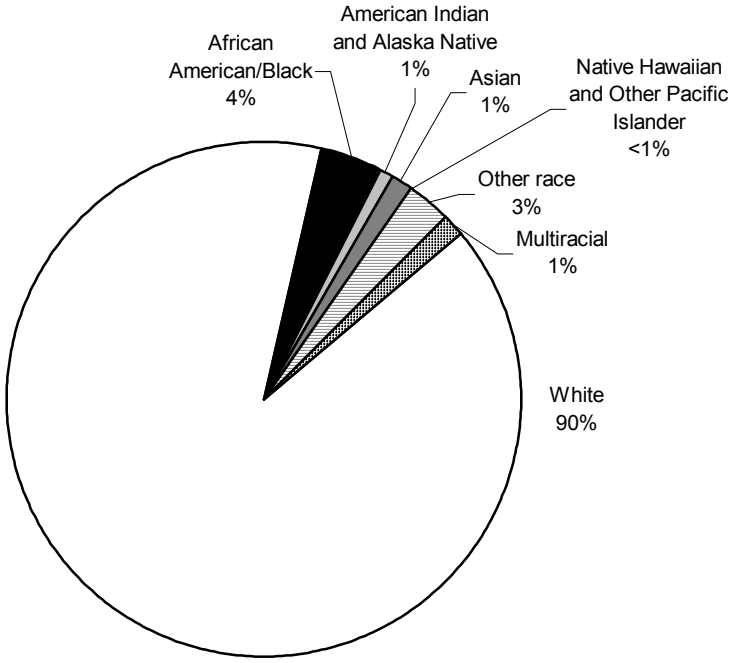
population. Four percent of Nebraska's population in 2000 was African American/Black, while 3 percent identified as a race other than those listed in the Census. One percent each identified as multiracial, Asian, and American Indian and Alaska Native. The Census category Hispanic or Latino refers to people of any race; 6 percent of Nebraska's population was in this category.

Of Nebraska's 93 counties, all but nine have a population that is 90 percent or more White, and in all but one, White residents are the majority. The exceptions are:

- Douglas and Sarpy Counties in the Omaha metropolitan area, which are more diverse than the state as a whole, with higher representation of almost every racial/ethnic group than the state as a whole.
- Colfax, Dakota, Dawson, Hall, and Scotts Bluff Counties, which have proportions of Hispanic/Latino residents[3] that are double or triple the state average.
- Thurston County, which has a 52 percent majority of American Indian and Alaska Native residents and is home to the reservation of the Winnebago Tribe of Nebraska.[4]
- Sheridan County, which is 9 percent American Indian and Alaska Native and includes part of the Pine Ridge Reservation of the Oglala Sioux.[5]

Appendix II presents the percent of residents in each county by racial and ethnic category. ***Chart 1*** shows the racial composition of Nebraska.

Chart 1:
Racial Composition of Nebraska in the 2000 Census



[3] In the Census data, Hispanic/Latino is not a separate racial category but rather can apply to people of any race. All of these counties also had higher proportions than the state as a whole of respondents indicating they were "some other race."
[4] Tiller Research, Inc., for the U.S. Department of Commerce, Economic Development Administration, "Nebraska", *American Indian Reservations and Trust Areas*, p. 411. April 2000. Available online: http://12.39.209.165/ImageCache/EDAPublic/documents/pdfdocs/27nebraska_2epdf/v1/27nebraska.pdf (Accessed: September 24, 2003).
[5] Ibid.

Income and Poverty in the National Context

Many low-income individuals and families are forced to make critical choices when their income is not sufficient to meet their basic living needs. It may mean fewer meals, no health care, loss of utilities, overcrowded housing, or eviction. For people living with HIV/AIDS who have low incomes, these choices can have a serious effect on their health status. Unfortunately, the income gap between the poorest and richest families in the nation has reached a historic peak. In 45 states, the income of the richest 20 percent of households has increased at a faster rate than that of the 20 percent with the lowest incomes.[6]

The HIV Cost and Services Utilization Study conducted in 1996, the most comprehensive study to date, presents a statistical snapshot of the economic well-being of people living with HIV/AIDS. At the time of the study, 63 percent were unemployed, 46 percent had a household income of less than $10,000, 78 percent had no private health insurance, and 20 percent had no health insurance.[7]

With more than 8 million people out of work, the U.S. unemployment rate has reached its highest percentage since 1994. At the beginning of 2003, the percent of workers on the unemployment roll hovered around 5.8; however, among African Americans the rate was nearly double at 10.9 percent.[8] An estimated 12 percent of the population—33 million people—is considered to be living in poverty in this country. The poverty rate is highest in the South, compared to other regions of the country. [9]

For many low-income and disabled persons in the United States, the cost of health care serves as a significant economic barrier to housing. Among the general population, an estimated 41 million, or 16 percent of non-elderly Americans, are uninsured.[10] People with HIV/AIDS who are able to qualify for Supplemental Security Income (SSI) due to their disability status are usually eligible for health coverage through Medicaid or Medicare, depending on personal income, age, and state regulations. However, the application period can range from a few months to a few years. Under the Medicaid program, participants are usually eligible as soon as their disability status is approved, while under Medicare requirements there may be a one- to two-year waiting period.

Median Family Income and Poverty in Nebraska

Every year, the U.S. Department of Housing and Urban Development (HUD) estimates a Median Family Income (MFI) for use with the Section 8 program. MFIs are set for metropolitan areas, for counties, and at the state level. HUD uses Census income data updated with more recent economic data to determine MFIs and intends them to be used to determine eligibility for HUD programs.

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[6] Jared Bernstein et al., *Pulling Apart: A State-by-State Analysis of Income Trends*, Center on Budget and Policy Priorities, Economic Policy Institute, p. viii. April 2002. Available online: www.cbpp.org/4-23-02sfp.pdf (Accessed: September 19, 2003).
[7] S.A., Bozzette et al., "The Care of HIV-Infected Adults in the United States," *New England Journal of Medicine*, vol. 339, no. 26, December 24, 1998.
[8] U.S. Department of Labor, Bureau of Labor Statistics, "The Employment Situation: August 2003," *News* (Washinngton, 2003) Available online: http://www.bls.gov/news.release/pdf/empsit.pdf (Accessed: September 24, 2003).
[9] U.S. Census Bureau, *Poverty in the United States: 2001*. Available online: www.census.gov/prod/2002pubs/p60-219.pdf. (Accessed: April 8, 2003), p. 5.
[10] The Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured, *The Uninsured and their Access to Health Care*, fact sheet, January 2003. Available online: www.kff.org/content/2003/142004/142004.pdf (Accessed: April 3, 2003).

MFI is the income level that divides the distribution of family incomes in a given geographic area in half. This means that half of the families in the area have more income than the median, and half have less income. MFIs are established for families consisting of one to eight people. This report will use the number established for a family of four unless otherwise noted. MFIs are useful for understanding the income levels in a given area and for comparing between areas.

The MFI established for Nebraska in 2003 for a family of four was $55,400, compared to the national MFI of $56,500. There was considerable variation between the MFI for metropolitan areas versus non-metropolitan areas—$63,800 compared to $48,300.[11] MFI varied from a high of $63,300 in the Omaha metropolitan area to a low of $28,900 in Loup County.[12]

Every year, the federal government also establishes a definition of poverty. It uses income thresholds based on household size; everyone who is in a household that is below the income threshold for that household size is considered to be living in poverty. In 2002, the poverty threshold for a single person under age 65 was $9,359 per year, equivalent to $780 per month. For a family of four, including two related children, the poverty threshold was $18,244 per year, equivalent to $1,520 per month.[13]

In Nebraska in 1999, the most recent year for which county-level data is available, 10 percent of residents were living in poverty. The poverty rate ranged from a low of 6 percent in Washington County to a high of 24 percent in Thurston County.[14] ***Appendix II*** presents the most recent MFI available and the percentage of people of all ages living in poverty for each county in the state.

[11] U.S. Department of Housing and Urban Development, Policy Development and Research Information, *Transmittal Notice on Estimated Median Family Incomes for FY 2003, State Median Family Incomes* "Attachement 2: FY 2003 Median Family Incomes for States, Metropolitan and NonMetropolitan Portions of States,". Available online: http://www.huduser.org/Datasets/IL/FMR03/HUD-Mediansa.pdf (Accessed: September 24, 2003).

[12] U.S. Department of Housing and Urban Development, Tables for 1999 & Estimated 2003 Decile Distributions by Metropolitan Statistical Areas and Non Metropolitan Counties, pp. 122-28. Available online: http://www.huduser.org/Datasets/IL/FMR03/Medians_2003.pdf (Accessed: September 24, 2003).

[13] Bernadette D. Proctor and Joseph Dalaker, Poverty in the United States: 2002, U.S. Census Bureau, September 2003. Available online: www.census.gov/prod/2003pubs/p60-222.pdf (Accessed: October 10, 2003)..

[14] U.S. Census Bureau, *QT-P34, Poverty Status in 1999 of Individuals: 2000*, . Available online: http://factfinder.census.gov/servlet/QTTable (Accessed: September 25, 2003).

HIV/AIDS in Nebraska

Advances in medical treatment combined with continuing new infections mean more people are now living with HIV and AIDS than ever before. Key facts include:

- 1,112 people were living with HIV/AIDS at the end of 2002, including 557 people living with AIDS and another 555 people living with HIV who had not been diagnosed with AIDS.
- 1,824 people have been diagnosed with HIV and/or AIDS in Nebraska since the epidemic began (AIDS reporting began in 1983 and HIV reporting began in 1995).
- While African Americans/Blacks make up only 4 percent of Nebraska's population, they accounted for 24 percent of those living with HIV or AIDS at the end of 2002.

In order to assess and plan for housing and services for people living with HIV/AIDS, it is important to have background information on the populations living with HIV/AIDS. This chapter of the plan presents HIV/AIDS epidemiology data from the Centers for Disease Control and Prevention and the Nebraska Department of Health and Human Services. The latter provided data upon request from AIDS Housing of Washington.

In 1981, the first case of AIDS (acquired immunodeficiency syndrome) was reported in the United States. The human immunodeficiency virus, HIV, is the virus that causes AIDS. While every state in the country tracks and reports AIDS cases, only some states track and report HIV cases. In Nebraska, AIDS reporting started in 1983 and HIV reporting started in 1995. However, Nebraskans have the right to be tested for HIV anonymously, meaning that a person's name is not recorded. (HIV cases identified through anonymous testing are not included in the data presented in this chapter.)

Information about both AIDS and HIV are presented in this chapter. First, living case data reflects the people who were living with HIV or AIDS at a point in time. Because this plan addresses the housing and service needs of people living with HIV or AIDS, living case data is significant. Second, cumulative case data reflects all reported cases since the epidemic began. People reflected in cumulative case data may now be living or deceased. Third, incidence rates put the number of people reported with HIV or AIDS in a geographic area in terms of a rate per population. Numbers of cases are typically described in terms of number per 100,000 people. This allows for comparisons between geographic areas of different size during an established period of time.

HIV/AIDS in the National Context

More people are now living with HIV and AIDS in the United States than ever before. The Centers for Disease Control and Prevention (CDC) estimates that between 800,000 and 900,000 individuals are living with HIV, the virus that causes AIDS, and that another 40,000 become infected every year.[15] They also estimate that one-fourth of the persons living with HIV in this country are not

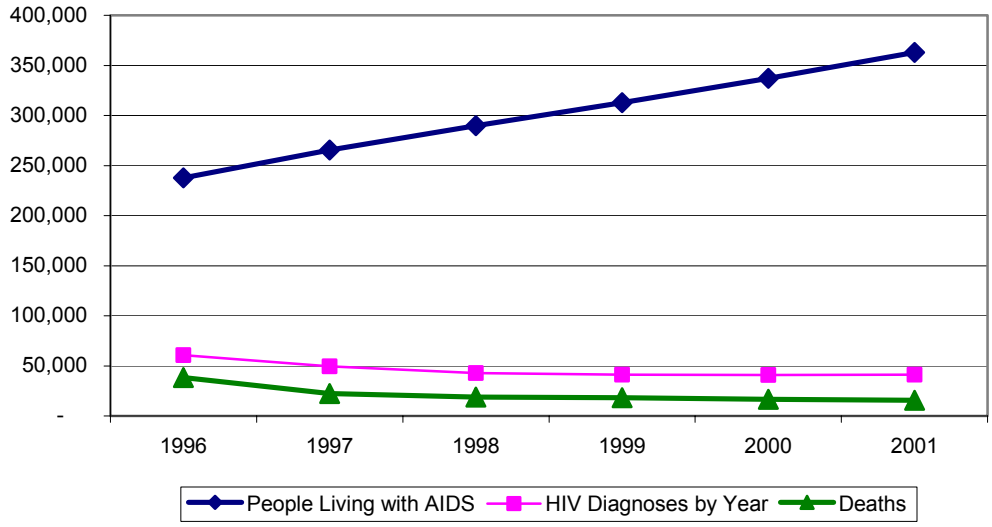
[15] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Update: A Glance at the HIV Epidemic*, December 2000. Available online: http://www.cdc.gov/nchstp/od/news/At-a-Glance.pdf (Accessed: September 19, 2003).

aware of their infection and their need for services.[16]

The American public continues to see HIV/AIDS as a serious public health concern (26 percent), second only to cancer (35 percent). Populations that are disparately affected by HIV/AIDS—African Americans, Latinos, young adults and their parents—consider AIDS a more urgent problem today than five years ago, compared to White respondents as a whole. Nearly half of the U.S. population (43 percent) say they personally know someone who is living with HIV/AIDS or has died of AIDS.[17]

Chart 2 shows the number of people living with AIDS, new HIV cases diagnosed, and the number of deaths from AIDS in the United States over a six-year period. Rates of new infections as well as rates of death from AIDS have remained steady over recent years. However, the number of people living with AIDS continues to climb as medical advances continue to slow progression of the disease and help individuals live longer.

Chart 2:
People Living with AIDS, HIV Diagnoses by Year, and Rates of Death in the United States, 1996–2001



Source: Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report, Year End 2001,* vol. 13, no. 2, tables 25, 29, and 31. Available online: www.cdc.gov/hiv/stats/hasr1202.htm (Accessed: April 2, 2003).

[16] Centers for Disease Control and Prevention, Epidemiology Program Office, "Update: AIDS—United States, 2000," *Morbidity and Mortality Weekly Report* vol. 5, no. 27 (July 12, 2002): pp. 592–595. Available online: www.cdc.gov/mmwr/PDF/wk/mm5127.pdf (Accessed: September 19, 2003).
[17] The Henry J. Kaiser Family Foundation, *The AIDS Epidemic at 20 Years: The View from America, A National Survey of Americans on HIV/AIDS, 2001*, p. 7. Available online: http://www.kff.org/content/2001/3026/aids20_rpt.pdf (Accessed: September 19, 2003).

Demographic Trends

The AIDS epidemic has become more complex over the past 20 years, as proven prevention programs have not reached everyone at risk. Originally found in large urban areas of the United States among men who have sex with men and injection drug users, the prevalence of HIV/AIDS among residents of the South, African Americans, Latinos, women, young adults, and persons exposed to HIV through heterosexual contact has increased disproportionately. Limited access to health care and preventive services, poverty, social disadvantage, discrimination, and stigma are some of the factors that have contributed to these trends. Approximately 10 percent of the AIDS cases reported were from metropolitan areas with populations less than 500,000 and 6 percent were from rural areas with populations less than 50,000.[18]

- African Americans make up 12 percent of the U.S. population, but accounted for half of new HIV cases reported in 2001. The AIDS rate among African Americans was nearly 10 times the rate reported among Whites.[19]
- African American women accounted for nearly 64 percent of new HIV cases reported among women in 2001. Hispanic/Latina and White women each accounted for 17 percent of reported HIV cases.[20] Overall, women make up an estimated 30 percent of new infections annually.[21]
- Hispanics/Latinos make up 13 percent of the U.S. population, but accounted for 19 percent of new HIV cases reported in 2000. The AIDS rate among Latinos/Hispanics was three times the rate reported among Whites.[22]
- Adolescents and young adults between the ages of 13 and 24 are estimated to make up half of new HIV infections. African American youth represent the majority of these infections. The CDC estimates that 47 percent of new cases among this age group are among females.[23]

Medical Advances in Treating People Living with HIV/AIDS

People living with HIV/AIDS who are being successfully treated with Highly Active Anti-Retroviral Therapy (HAART)—often referred to as combination therapies or the "cocktail"—are experiencing significant improvements in health. Many people living with HIV/AIDS are considering reemployment and evaluating the impact that returning to work could have on their disability and medical benefits.

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[18] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS in Urban and Nonurban Areas*, Fact Sheet, p. 4. Available online: www.cdc.gov/hiv/graphics/images/L206/L206.pdf (Accessed: April 2, 2003). Does not include Puerto Rico, U.S. Virgin Islands, and territories. Rural area defined as population less than 50,000.

[19] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, "HIV/AIDS Among African Americans Key Facts," *CDC Fact Sheet*, March 2003, p. 1. Available online: www.cdc.gov/hiv/pubs/Facts/afam.pdf (Accessed: September 19, 2003).

[20] Ibid., p. 2.

[21] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Update: A Glance at the HIV Epidemic*, December 2000. Available online: http://www.cdc.gov/nchstp/od/news/At-a-Glance.pdf (Accessed: September 19, 2003).

[22] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Among Hispanics in the United States*, Fact Sheet. Available online: www.cdc.gov/hiv/pubs/facts/hispanic.htm (Accessed: April 2, 2003).

[23] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *Young People at Risk: HIV/AIDS Among America's Youth*, Fact Sheet. Available online: http://www.cdc.gov/hiv/pubs/facts/youth.htm (Accessed: September 19, 2003).

However, some individuals with access to these medications are experiencing failure, even though they are being closely monitored and have medications adjusted frequently. In addition, not all people living with HIV/AIDS who might be helped by existing HIV treatments necessarily have access to them. The medications and monitoring associated with HAART are expensive—at $10,000 to $15,000 each year—putting them well out of reach for people who do not have adequate insurance or access to state-run AIDS Drug Assistance Programs (ADAP). Many states have waiting lists for access to ADAP resources. Studies show persisting disparities in access to these medications, particularly among women, people of color, and injection drug users.[24] Another study published in 2001 estimated that nearly all of the 750,000 people living with HIV in the United States would have met the criteria for being offered HAART, but that only about 200,000 were using it.[25]

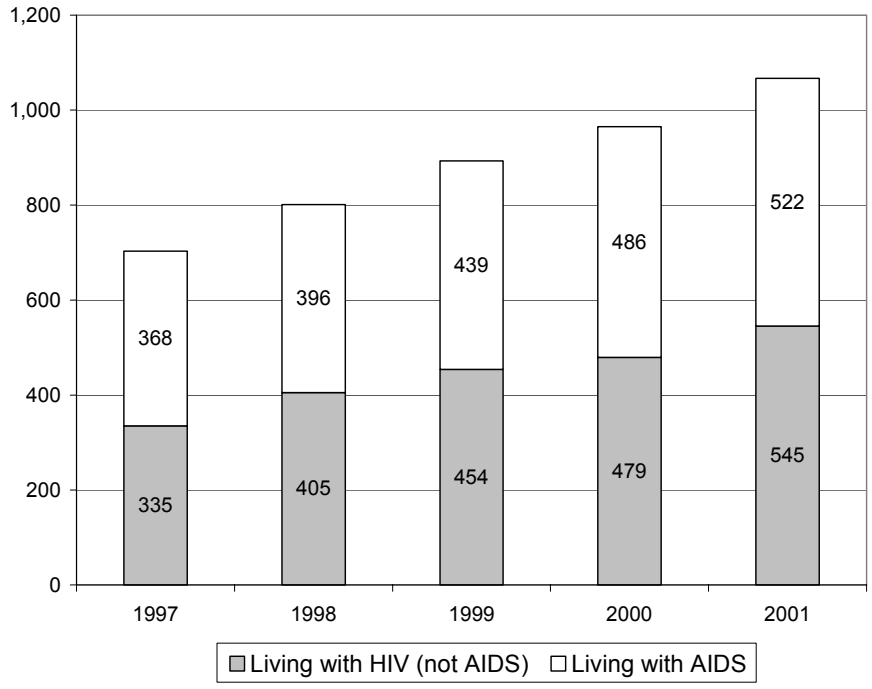
[24] Usha Sambamoorthi, Ph.D. et al., "Use of Protease Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors Among Medicaid Beneficiaries with AIDS," *American Journal of Public Health*, September 2001, vol. 91, no. 9, pp. 1474–1481..
[25] James G. Kahn, M.D., M.P.H.et al., "Health and Federal Budgetary Effects of Increasing Access to Antiretroviral Medications for HIV by Expanding Medicaid," *American Journal of Public Health*, September 2001, vol. 91, no. 9, pp. 1464–1473.

HIV/AIDS in Nebraska

People Living with HIV/AIDS

Medical advances that can prolong the lives of people living with HIV/AIDS, combined with continuing new infections, mean that more people are living with HIV/AIDS in Nebraska than ever before. ***Chart 3*** presents living HIV and AIDS case data from Centers for Disease Control and Prevention reports from 1997 through 2001.

Chart 3:
People Living with HIV and AIDS in Nebraska, 1997–2001



Sources: Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Reports Year End 1998–2001,* vols. 10–13, no. 2. Available online: www.cdc.gov/hiv/stats/hasrlink.HTM (Accessed: January 30, 2003). *HIV/AIDS Supplemental Surveillance Report: Characteristics of Persons Living with AIDS at the End of 1997*, vol. 5, no. 1, table 33. Available online: www.cdc.gov/hiv/stats/hasrsupp51.htm (Accessed: January 30, 2003).

Table 1 presents race/ethnicity, gender, age at diagnosis, and transmission category data for people living with HIV (without an AIDS diagnosis) and with AIDS.

Table 1:
Living HIV and AIDS Cases in Nebraska, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, reported through December 31, 2002

Demographics	Living HIV Cases (no AIDS diagnosis)		Living AIDS Cases	
	Number	Percent	Number	Percent
Race/Ethnicity				
White/Caucasian	340	61%	338	61%
African American/Black	134	24%	131	24%
Hispanic/Latino	58	10%	76	14%
Asian/Pacific Islander	*	1%	4	1%
American Indian/Alaska Native	16	3%	8	1%
Other	4	1%	—	—
Total	**555**	**100%**	**557**	**100%**
Gender				
Male	419	75%	460	83%
Female	136	25%	97	17%
Total	**555**	**100%**	**557**	**100%**
Age at Diagnosis				
0 to 9	7	1%	4	1%
10 to 19	17	3%	*	1%
20 to 29	200	36%	118	21%
30 to 39	227	41%	268	48%
40 to 49	80	14%	122	22%
50+	24	4%	42	8%
Total	**555**	**100%**	**557**	**100%**
Transmission Category				
Men who have sex with men (MSM)	243	44%	274	49%
Injection Drug Use (IDU)	56	10%	63	11%
MSM/IDU	43	8%	52	9%
Hemophilia	*	<1%	8	1%
Transfusion	4	1%	9	2%
Heterosexual	95	17%	68	12%
Pediatric	7	1%	6	1%
Risk not identified	105	19%	77	14%
Total	**555**	**100%**	**557**	**100%**

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003.

Note: AIDS cases diagnosed between January 1983 and December 2002; HIV cases diagnosed between July 1995 and December 2002; living as of December 31, 2002. Percents may not total 100 due to rounding.

*Total number of reported HIV or AIDS cases are three or less. Number of cases less than 4 are not entered to protect the privacy of individuals with HIV/AIDS.

Table 2 presents data about living HIV and AIDS cases by Nebraska Health Planning Region reported through December 31, 2002.

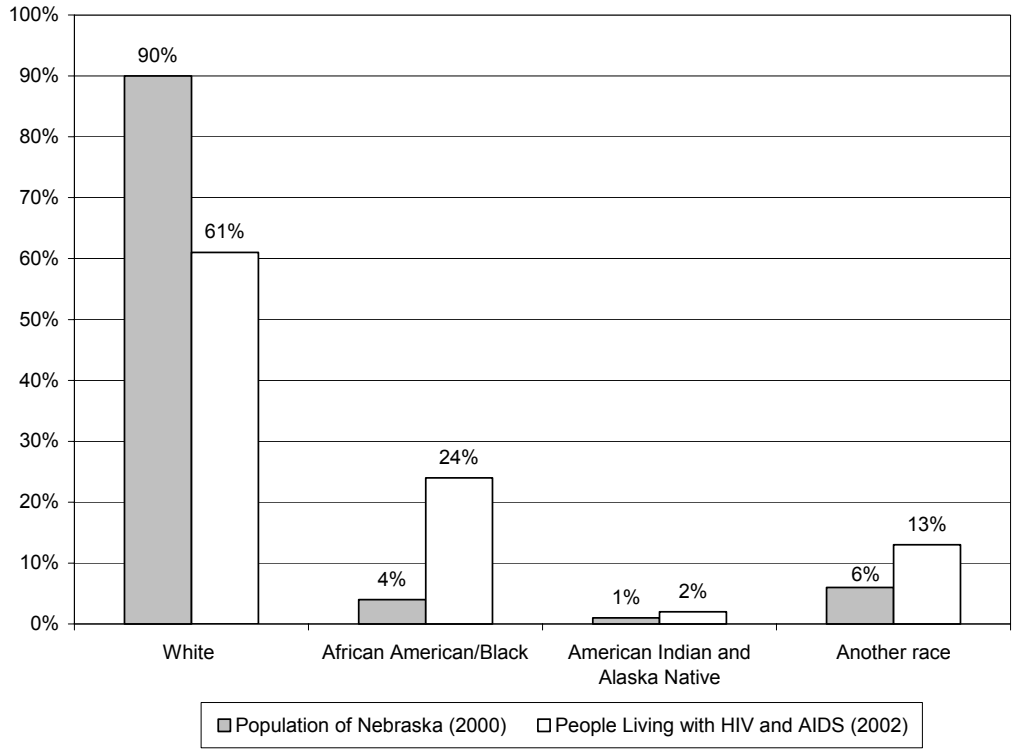
Table 2:
People Living with HIV or AIDS, by Nebraska Health Planning Region, reported through December 31, 2002

Health Planning Regions		Living HIV Cases (no AIDS diagnosis)		Living AIDS Cases	
Region	**Counties**	**Number**	**Percent**	**Number**	**Percent**
Central	Adams, Blaine, Buffalo, Clay, Custer, Franklin, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, Wheeler	26	5%	35	6%
Midlands	Dodge, Douglas, Sarpy, Washington	364	66%	374	67%
Northern	Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, Wayne	26	5%	26	5%
Panhandle	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux	7	1%	11	2%
Southeast	Butler, Cass, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, York	125	23%	100	18%
West Central	Arthur, Chase, Dawson, Dundy, Frontier, Furnas, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, Thomas	7	1%	11	2%
	Statewide Total	**555**	**100%**	**557**	**100%**

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003.
Note: Percents may not total 100 due to rounding.

Chart 4 compares the race/ethnicity of the entire population of Nebraska to people living with HIV/AIDS in the state at the end of 2002. Hispanics/Latinos living with HIV/AIDS are included in the "another race" category, since Hispanic/Latino is tracked as a distinct race in epidemiology data, but as an ethnicity in combination with race in Census data. A total of 12 percent of people living with HIV or AIDS are Hispanic/Latino, compared to 6 percent in the Census; however, these 6 percent are included in another race category in the Census data.

Chart 4:
Race/Ethnicity of Nebraska Total Population (2000) and People Living with HIV and AIDS, reported through December 31, 2002



Sources: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003. U.S. Census Bureau, *GCT-PL, Race and Hispanic or Latino*. Available online: factfinder.census.gov/servlet/BasicFactsServlet (Accessed: September 25, 2003).

Cumulative Reported HIV/AIDS Cases

Table 3 presents cumulative HIV and AIDS case data in a demographic profile of cases reported through December 31, 2002.

Table 3:
Cumulative HIV and AIDS Cases in Nebraska, by Race/Ethnicity, Gender, Age at Diagnosis, and Transmission Category, reported through December 31, 2002

Demographics	Cumulative HIV Cases (no AIDS diagnosis)		Cumulative AIDS Cases	
	Number	Percent	Number	Percent
Race/Ethnicity				
White/Caucasian	359	61%	853	69%
African American/Black	141	24%	245	20%
Hispanic/Latino	65	11%	115	9%
Asian/Pacific Islander	*	1%	6	<1%
American Indian/Alaska Native	16	3%	17	1%
Other	4	1%	—	—
Total	**588**	**100%**	**1,236**	**100%**
Gender				
Male	447	76%	1,060	86%
Female	141	24%	176	14%
Total	**588**	**100%**	**1,236**	**100%**
Age at Diagnosis				
0 to 9	7	1%	9	1%
10 to 19	17	3%	9	1%
20 to 29	210	36%	266	22%
30 to 39	238	40%	571	46%
40 to 49	90	15%	277	22%
50+	26	4%	104	8%
Total	**588**	**100%**	**1,236**	**100%**
Transmission Category				
Men who have sex with men (MSM)	253	43%	668	54%
Injection Drug Use (IDU)	61	10%	128	10%
MSM/IDU	44	7%	118	10%
Hemophilia	4	1%	37	3%
Transfusion	5	1%	24	2%
Heterosexual	101	17%	119	10%
Pediatric	7	1%	10	1%
Risk not identified	113	19%	132	11%
Total	**588**	**100%**	**1,236**	**100%**

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003.

*Total number of reported HIV or AIDS cases is three or less. Numbers of cases less than 4 are not entered to protect the privacy of individuals with HIV/AIDS. Percents may not total 100 due to rounding.

Table 4 presents data about cumulative HIV and AIDS cases by Nebraska Health Planning Region reported through December 31, 2002.

Table 4:
Cumulative HIV and AIDS Cases, by Nebraska Health Planning Region, reported through December 31, 2002

Health Planning Region	Cumulative HIV Cases (no AIDS diagnosis)		Cumulative AIDS Cases	
	Number	Percent	Number	Percent
Central	29	5%	75	6%
Midlands	374	64%	813	66%
Northern	29	5%	60	5%
Panhandle	8	1%	29	2%
Southeast	140	24%	235	19%
West Central	8	1%	24	2%
Statewide	**588**	**100%**	**1,236**	**100%**

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003.

Note: See Table 2 for the listing of counties included in each Health Planning Region. Note: Percents may not total 100 due to rounding.

AIDS Case Rate

Another way of looking at the prevalence of AIDS is to calculate the number of AIDS cases per 100,000 population in a year. This compares the number of new cases with the total population of an area. Among the 50 states, Nebraska ranked 38th with an annual case rate of 4. per 100,000 people in 2001. In comparison, Missouri had a case rate of 7.9, Colorado 6.5, Kansas 3.6, South Dakota 3.3, Iowa 3.1, and Wyoming 1.0.[26]

[26] Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Divisions of HIV/AIDS Prevention, *HIV/AIDS Surveillance Report Year-end 2001,* vol. 13, no. 2, table 2. Available online: www.cdc.gov/hiv/stats/hasr1302/table2.htm (Accessed: September 25, 2003).

Housing and Homelessness and Related Issues

People living with HIV/AIDS have experiences similar to many other people with low incomes in their communities. The following pages present information about housing and homelessness in Nebraska. Key facts include:

- Many people have difficulty paying housing costs. For example, in Omaha, a one-bedroom apartment at Fair Market Rent is unaffordable to a full-time minimum wage worker.
- Some Nebraskans face homelessness, and many more are at risk. A 1995 study estimated that 9,280 people were homeless in Nebraska over a twelve-month period, including 4,200 children.
- The Nebraska Homeless Assistance Program provides funding for homeless services.

The following pages present information related to housing affordability, Nebraska's housing market, and homelessness that is not specific to people living with HIV/AIDS.

Housing Affordability

National Context

Unprecedented economic growth in the 1990s has not raised all incomes equally, although it has raised housing costs. In 2001, there were no states where a full-time, minimum-wage worker could afford a two-bedroom apartment renting at or above the federally established Fair Market Rent.[27]

Clearly, people with disabilities who depend on SSI—equivalent in 2003 to just 18 percent of the national median income for an individual—have even fewer housing choices. For the first time ever, in 2002, the national average rent was greater than the annual income provided by the SSI program—105 percent of SSI would be needed to rent a modest one-bedroom apartment. From 2000 to 2002, the cost of rental housing rose twice as high as the cost-of-living adjustments for SSI.[28] The Joint Center for Housing Studies of Harvard University reported that of the 34 million renter households in the nation, 14 million were spending more than 30 percent of their incomes for housing, while 7 million were spending 50 percent or more in 2001.[29]

People living with HIV/AIDS who have low incomes face the same challenges and frequently turn to the same resources to meet their housing and service needs as other people with low incomes. A small portion of people with low incomes are able to meet their housing needs with assistance, either in the form of subsidized units or through vouchers that a tenant can use in available market-rate housing. When it is not possible to obtain affordable housing, residents with low incomes inevitably either pay a larger percentage of their income toward housing costs than people earning higher incomes, or they combine households to share housing costs. Individuals who pay a high

[27] Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2001*, June 2001, p. 22. Available online: www.gsd.harvard.edu/jcenter (Accessed: January 9, 2002).
[28] Technical Assistance Collaborative, Inc., *Priced Out in 2002*, May 2003, p. 1. Available online: www.tacinc.org (Accessed: June 23, 2003).
[29] Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2002*, June 2002, p. 19. Available online: www.gsd.harvard.edu/jcenter (Accessed: March 14, 2003).

proportion of their income for housing costs and those who are living in overcrowded situations are at increased risk for homelessness.

Both homeownership and rental housing occupy important niches on the housing continuum. However, gains in support for homeownership may have come at the expense of support for rental housing.[30] Rents, adjusted for inflation, increased 15 percent during the past four years, four times faster than the cost of a new home.[31] However, mortgage interest tax deductions represent the largest federal housing subsidy program, valued at $65 billion in FY 2001.[32] Nationally, homeownership rates in rural areas are typically higher than in urban areas.[33] In relation to people living with HIV/AIDS, this could have impacts such as a greater need for mortgage assistance or home repair services, or fewer rental-housing opportunities than would be true in more urban areas.

Housing Affordability in Nebraska

Housing affordability is determined by the relationship of housing cost to income. HUD considers housing to be affordable if it costs 30 percent or less of the renter's gross income. An area with very high average incomes can still be unaffordable if rents are typically very high; conversely, very low rents can be unaffordable in areas where incomes are low. Individuals who pay more than they can afford for rent are at increased risk of homelessness. It is important to understand the effect housing costs can have on the housing stability of low-income families.

Many low-income people need financial support in order to meet housing costs. Housing authorities throughout Nebraska work to provide affordable housing, including housing subsidies, to community members in both rural and urban areas. In 2003, a total of 7,606 public housing units and 11,552 Section 8 vouchers were available through more than one hundred housing authorities in the state.[34] Fair Market Rent (FMR) is established by HUD as the rental cost limit for certain rental subsidy programs, including Section 8.[35] FMR is not intended to represent the actual cost of available units but is useful as an estimate of housing costs for an area. ***Appendix II*** includes a listing of resources available through each Housing Authority in Nebraska and the Fair Market Rent for 2003 for every county of Nebraska, for studios, and one-, two-, and three-bedroom units.

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[30] National Low Income Housing Coalition, "Homeownership," *2002 Advocates' Guide To Housing and Community Development Policy.* Available online: www.nlihc.org/advocates/homeownership.htm (Accessed: September 25, 2003).

[31] Joint Center for Housing Studies of Harvard University, *The State of the Nation's Housing: 2002*, June 2002, p. 19. Available online: www.gsd.harvard.edu/jcenter (Accessed: March 14, 2003).

[32] Millennial Housing Commission, "Tax Expenditures," *Housing Program Tutorial: Federal Housing Assistance*, June 2002, Slide 21. Available online: www.mhc.gov/tutorial_files/frame.htm (Accessed: September 25, 2003).

[33] The USDA reported a 75 percent rural homeownership rate in 2000, compared to 67 percent for the country as a whole. U.S. Department of Agriculture, Rural Development, *Rural Homeownership Remains High*, News Release, June 7, 2001. Available online: www.rurdev.usda.gov/ne/pas/FY01homepr.pdf (Accessed: September 25, 2003).

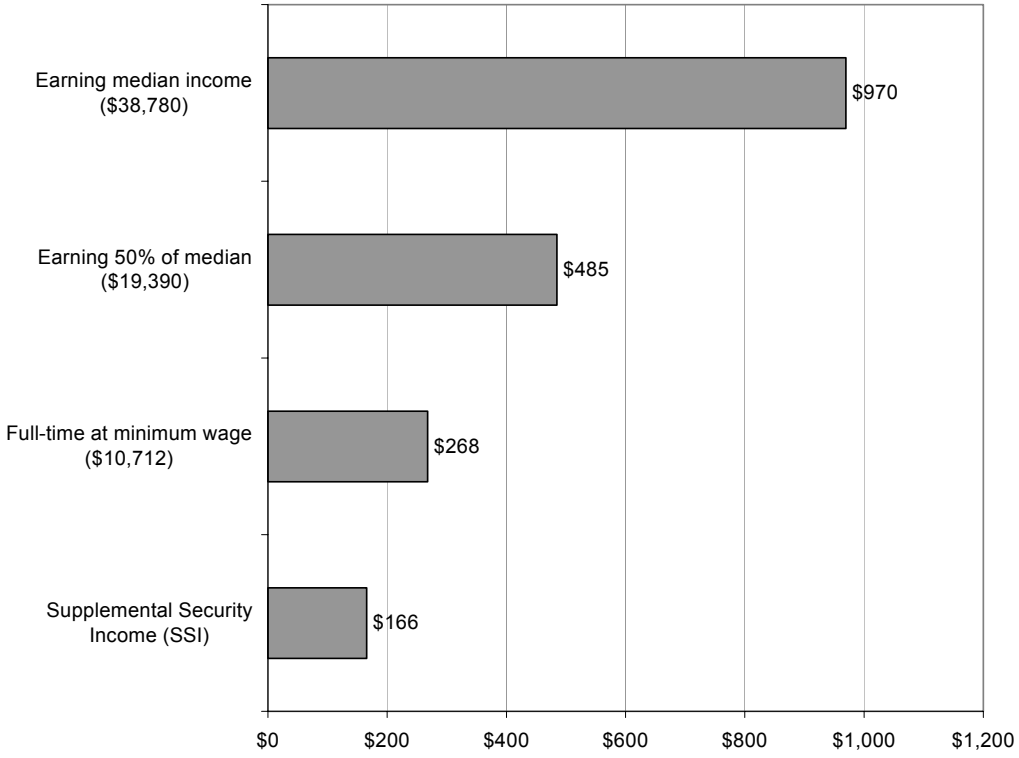
[34] Housing Authority Low Rent Inventory and Section 8 vouchers are available from the U.S. Department of Housing and Urban Development's PIH [Public and Indian Housing] Information Center (PIC). Available online: www.hud.gov/offices/pih/systems/pic/haprofiles/index.cfm (Accessed: September 25, 2003). Housing Authority inventory information has not been independently verified by AIDS Housing of Washington. Inventory represents the resources of the housing authority, not the availability of these resources. See Table A-5 for a listing of resources by housing authority.

[35] FMRs are set for each county at the 40th percentile of rents paid by people who moved within the past two years, excluding people who moved into newly constructed units. This means that 40 percent of rents were lower and 60 percent were higher than FMR.

Housing Affordability Scenarios

It is helpful to consider the impact of housing costs on individuals and families with different household incomes. ***Chart 5*** shows affordable monthly housing costs for four income scenarios.

Chart 5:
Affordable Monthly Housing Cost in Nebraska



Note: Assumes the maximum monthly federal SSI payment for a single person living alone in 2003 ($552 per month), the federal minimum wage ($5.15 per hour), and the state's median income for a single person in 2003 ($38,780 annually). The State of Nebraska may supplement the federal SSI payment for elderly or disabled citizens based on an individual's monthly expenses.

The following tables include affordability scenarios for an individual and for a family of four receiving Supplemental Security Income (SSI), working full-time at minimum wage, and earning 50 percent of median income. The difference between the rent affordable to the individual or family and the FMR is given for each scenario. Information for Gage County is presented because the median income there is midway through the range of median incomes reported for the state, and it has the same FMR as many counties in the state; it is intended as an illustration of an "average" county. ***Table 5*** uses FMR to approximate housing affordability for an individual in Gage County and ***Table 6*** uses FMR to approximate housing affordability for a family of four in Gage County.

Table 5:

Monthly Housing Affordability for Individuals with Varying Incomes in Gage County

	Individual A	Individual B	Individual C
Earns:	SSI	Minimum wage	50% of MFI
Has this much monthly income:	$552	$893	$1,432
Which is equivalent to this percentage of MFI:	19%	31%	50%
Based on income, affordable housing cost is:	$166	$268	$430
*A studio apartment might cost:	$253	$253	$253
Which exceeds the affordable cost by:	$87	none	none
*A one-bedroom apartment might cost:	$327	$327	$327
Which exceeds the affordable cost by:	$161	$59	none

Sources: U.S. Department of Housing and Urban Development, HUD User, *FY 2003 Income Limits*. Available online: http://www.huduser.org/Datasets/IL/FMR03/Medians_2003.pdf (Accessed: September 22, 2003). U.S. Department of Housing and Urban Development, HUD User, *Fair Market Rents 2003*. Available online: www.huduser.org/datasets/fmr.html (Accessed February 26, 2003).

*2003 Fair Market Rent established by HUD.

Notes: SSI is Supplemental Security Income. The amount given is the maximum for a single person 65 or younger living alone in 2003. The State of Nebraska may supplement the federal SSI payment for elderly or disabled citizens based on an individual's monthly expenses. MFI is Median Family Income. The MFI established by HUD for a family of one in Gage County, Nebraska in 2003 is $34,370, equivalent to $2,864 per month. Affordable housing cost here is based on HUD's guideline of 30 percent or less of gross monthly income. Minimum wage in 2003 is $5.15 per hour. Minimum wage example assumes full-time employment.

Table 6:

Monthly Housing Affordability for Families with Varying Incomes in Gage County

	Family A	Family B	Family C
Earns:	SSI	Minimum wage	50% of MFI
Has this much monthly income:	$552	$893	$2,046
Which is equivalent to this percentage of MFI:	13%	22%	50%
Based on income, affordable housing cost is:	$166	$268	$614
*A two-bedroom apartment might cost:	$424	$424	$424
Which exceeds the affordable cost by:	$258	$156	none
*A three-bedroom apartment might cost:	$539	$539	$539
Which exceeds the affordable cost by:	$373	$271	none

Sources: U.S. Department of Housing and Urban Development, HUD User, *FY 2003 Income Limits*. Available online: www.huduser.org/datasets/il.html (Accessed: February 26, 2003). U.S. Department of Housing and Urban Development, HUD User, *Fair Market Rents 2003*. Available online: www.huduser.org/datasets/fmr.html (Accessed February 26, 2003).

*2003 Fair Market Rent established by HUD.

Notes: SSI is Supplemental Security Income. The amount given is the maximum for a single person 65 or younger living alone in 2003. The State of Nebraska may supplement the federal SSI payment for elderly or disabled citizens based on an individual's monthly expenses. MFI is Median Family Income. The MFI established by HUD for a family of four in Gage County, Nebraska in 2003 is $49,100, equivalent to $4,092 per month. Affordable housing cost here is based on HUD's guideline of 30 percent or less of gross monthly income. Minimum wage in 2003 is $5.15 per hour. Minimum wage example assumes one adult working full-time.

Gage County offers an illustration of an "average" county in Nebraska; however, housing affordability varies from county to county. For example:

- The FMR for a one-bedroom unit in Loup County exceeds the affordable rent for an individual earning minimum wage ($893 per month) by $58 per month. Additionally, FMR for a three-bedroom unit in Loup County exceeds the affordable rent for a family of four earning minimum wage ($893 per month) by $264 per month.
- In the Omaha metropolitan area, higher FMRs create even larger affordability gap. An individual earning minimum wage will experience a $224 gap between the FMR for a one-bedroom unit and what that person can afford to pay in rent. The gap is even larger for a family of four earning minimum wage and renting a three-bedroom unit, equaling $546 per month.

Housing Planning and Funding

Nebraska **Department of Economic Development** (DED) programs focus on the development of economic opportunities and community resources in Nebraska. DED administers Nebraska's allocations of certain federal housing and community development funds and state-generated resources that address affordable housing and homelessness. Specific programs of the department's Community and Rural Development Division support the development of housing affordable to low- and moderate-income Nebraskans.[36]

The Nebraska **Commission on Housing and Homelessness,** founded in 1998, is a statewide advisory committee that provides input to the governor and DED on a range of policy and program issues related to affordable housing and homelessness. The commission is comprised of a diverse group of community stakeholders from around the state.

DED's **Affordable Housing Program** combines funding received by Nebraska from two federal programs—the U.S. Department of Housing and Urban Development's Community Development Block Grant (CDBG) program and the HOME Investment Partnerships (HOME) program—with Nebraska Affordable Housing Trust Fund resources to comprehensively respond to affordable housing issues in the state.

The **2001 Nebraska Housing Market Report** assessed housing needs in the state, particularly the needs of and the resources available to low-income residents. Prepared by the University of Nebraska-Lincoln's Center for Applied Rural Innovation, the report used multiple sources of data to comprehensively address three primary questions: (1) What housing stock and housing programs currently exist in Nebraska?; (2) What housing stock and programs are needed?; and (3) What can be done to meet the housing needs? The findings of the study were organized by geographic region, and recommendations of the report included consistent planning and data collection, more education, and increased development of new affordable housing resources.

[36] A description of Nebraska Department of Economic Development programs is available online: www.neded.org (Accessed: August 5, 2003).

Consolidated Plans

The U.S. Department of Housing and Urban Development (HUD) requires jurisdictions that are funded under certain formula grant programs (Community Development Block Grant, Emergency Shelter Grant Program, HOME Investment Partnerships Program, and Housing Opportunities for Persons with AIDS) to complete an annual planning and reporting document called a Consolidated Plan. The State of Nebraska, the City of Omaha, and the City of Lincoln all complete Consolidated Plans.

State of Nebraska, 2000–2005 Consolidated Plan

The state's most recent Consolidated Plan was prepared by the Nebraska Department of Economic Development, Division of Community and Rural Development, and was last revised in June 2000. The Consolidated Plan identified the following housing strategies:

- Promote an adequate supply of quality, affordable, appropriate housing for low- and moderate-income individuals and families, both renters and homeowners, including persons with special housing needs.
- Overcome barriers to homeownership for low- and moderate-income individuals and families, including persons with special housing needs.
- Promote an adequate supply of quality affordable, appropriate rental housing as a choice when homeownership is not a feasible option for low- and moderate-income individuals and families, including persons with special housing needs.
- Support and facilitate an active and effective regional continuum-of-care planning and delivery system, focusing on a comprehensive approach to housing and service delivery to people who are homeless and near-homeless.
- Identify and address the barriers to homeownership, rental housing, support services, and shelters due to violations of fair housing practices.
- Identify and address a strategy for reduction of lead-based paint hazards in rural areas of the state.[37]

Omaha/Council Bluffs Consortium, Consolidated Submission (2003 to 2007)

The Omaha/Council Bluffs Consortium *Consolidated Submission for Community Development Programs for Fiscal Years 2003 to 2007*, from September 2002, establishes "the conservation of established neighborhoods, and the preservation of their housing stock, the creation of affordable housing and special needs housing, and program-related housing counseling" as its primary housing objective. It establishes a number of strategies around single-family home rehabilitation, rental rehabilitation, accessible housing, and housing development. Selected strategies that may affect people living with HIV/AIDS more directly include:

- To continue to provide assistance to people with special needs and to senior citizens
- To provide sound rental housing for low- and moderate-income residents
- To increase the supply of handicapped-accessible units
- To expand homeownership opportunities for low- and moderate-income residents[38]

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[37] Nebraska Department of Economic Development, Division of Community and Rural Development, *2000–2005 Consolidated Plan: Housing and Community Development Programs,* June 28, 2000, part 5-6.
[38] Omaha-Council Bluffs Consortium, *Consolidated Submission for Community Development Programs for Fiscal Years 2003 to 2007*, September 2002, pp. 177–180.

The Action Plan also includes some discussion of the housing needs of people living with HIV/AIDS. It describes the services available through the Nebraska AIDS Project, reports that some Omaha Housing Authority senior citizen complexes include some units set aside for people with disabilities where people living with AIDS may live, and anticipates an increasing need for housing for this population.[39]

City of Lincoln, Nebraska, Consolidated Plan FY 2000–FY 2003

The City of Lincoln's *Consolidated Plan FY 2000–FY 2003* includes an inventory of assisted permanent rental housing. The inventory had a maximum capacity of 5,056 units, which included 2,795 tenant-based Section 8 vouchers.

The Consolidated Plan also outlined the following housing goals:

- Promote the preservation, maintenance, and renovation of substandard or inadequate housing throughout the city, with emphasis on the Neighborhood Revitalization Strategy Area and low-income areas.
- Promote the preservation and revitalization of older areas as well as the "self-sufficiency" of lower-income families through increased opportunities for homeownership.
- Increase the supply of affordable housing for low- and moderate-income households (renters and homebuyers), including persons with special needs.
- Strengthen or establish policies, procedures, and institutions that support and maintain the quality, affordability, and availability of housing for lower-income households and preserve and enhance the quality of life in older neighborhoods.
- Affirmatively further fair housing and increase fair housing opportunities throughout the city through the removal of barriers/impediments to fair housing.[40]

Local Housing Plans

Some communities develop housing documents to guide local planning efforts. One example is the plan developed by the City of Grand Island. The *Grand Island, Nebraska, Housing Market Study 2006*, published in 2001, established priority housing needs based on both quantitative and qualitative housing planning research. The first priority listed included housing for people with disabilities.[41]

[39] Ibid., pp. 195–196.
[40] City of Lincoln, Nebraska, Urban Development Department, *Consolidated Plan FY 2000–FY 2003 for HUD Entitlement Programs*, June 2000, pp. V-3, V-17–V-19.
[41] Hanna:Keelan Associates, P.C., *Grand Island, Nebraska Housing Market Study 2006: A Five-Year Housing Initiative,* 2001, p.3.1.

Homelessness and Related Issues

National Context

The housing affordability crisis in the United States has been a driving factor for a burgeoning homeless population. It is estimated that on any given night, more than 700,000 Americans are homeless, and as many as 3.5 million are homeless at some point each year.[42] The U.S. homeless population has an estimated median rate of HIV prevalence at least three times higher—3 percent versus 1 percent—than the general population.[43] Among close to 12,000 people living with HIV/AIDS surveyed by AIDS Housing of Washington in 33 areas around the country since 1995, 40 percent indicated they had been homeless at some point in their lives and 11 percent were homeless when they completed the survey.[44]

When people are unable to afford housing, they are at risk of becoming homeless. People staying in homeless shelters represent a portion of the homeless population; other marginally housed people may be staying in substandard housing, in cars, or in temporarily doubled-up situations with friends or relatives. Homeless services are available but meet only part of the outstanding need.

The National Alliance to End Homelessness, a national homeless advocacy organization, outlines steps to address the epidemic of homelessness in the United States in its *Ten Year Plan to End Homelessness*. Data collection, planning, homelessness prevention, and affordable housing development were identified as key components of effective intervention aimed at eliminating homelessness. Communities around the country are developing concrete plans to end homelessness in their region, based on this model.

Rural Homelessness

Homelessness in urban areas looks different from rural areas. While a person without a regular place to stay in an urban area may sleep in an emergency shelter or in a public place, people without a place to stay in rural areas are more likely to move in with friends or family and stay for as long as they can, then seek shelter in places not intended for permanent habitation, including abandoned shacks, vehicles, and campgrounds.[45] This means that people who are homeless in rural areas are less visible, making it difficult to estimate the true extent of rural homelessness.[46]

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[42] National Alliance to End Homelessness, *The Ten Year Plan to End Homelessness,* 2000. Available online: http://www.endhomelessness.org/pub/tenyear/demograp.htm (Accessed: September 21, 2003).

[43] Higher rates (8.5 to 62 percent) have been found in selected homeless subpopulations. John Song, , M.D., M.P.H., M.A.T., *HIV/AIDS & Homelessness: Recommendations for Clinical Practice and Public* Policy - November 1999, National Health Care for the Homeless Council, Health Care for the Homeless Clinician's Network, p. 1. Available online: http://www.nhchc.org/Publications/HIV.pdf (Accessed: September 19, 2003).

[44] AIDS Housing of Washington, AHW *Fact Sheet, Spring 2003: AIDS Housing Survey*. Available online: http://www.aidshousing.org/usr_doc/Survey_Factsheet_2003.pdf (Accessed: September 19, 2003). Areas represented are: Alameda County, CA; Atlanta, GA; Chicago, IL; Columbia, SC, Contra Costa County, CA; Dallas, TX; Fresno, CA; Greensboro, NC; Miami, FL; Monterey County, CA; Orange County, CA; Palm Beach County, FL; Philadelphia, PA; Phoenix, AZ; Pittsburgh, PA; Portland, OR; Riverside/San Bernardino Counties, CA; San Diego, CA; Snohomish County, WA; Suburban Virginia, Washington, DC; and the states of Colorado, Indiana, Kentucky, Maryland, Montana, North Dakota, Oregon, South Dakota, Utah, Virginia, Washington, and West Virginia, between 1995 and 2003.

[45] Patricia A., Post, M.P.A., *Hard to Reach: Rural Homelessness & Health Care*, National Health Care for the Homeless Council, January 2002, p. 8. Available online: http://nhchc.org/Publications/RuralHomeless.pdf (Accessed: September 19, 2003).

[46] Housing Assistance Council, *Information About . . . Rural Homelessness: The Problem*. Available online: http://www.ruralhome.org/pubs/infoshts/rhomeles.htm (Accessed: September 19, 2003).

Nationally, studies have found that people who are homeless in rural areas are more likely to be "white, female, married, currently working, homeless for the first time, and homeless for a shorter period of time" than people who are homeless in urban areas. In addition, domestic violence is more likely to be involved, and substance use is less likely to be involved.[47] A 1996 study of people living in rural America who were receiving homeless services found that 55 percent had an "alcohol problem," 30 percent had a "mental health problem," and 21 percent had a "drug problem." At the same time, 65 percent had worked for pay in the past month, but only 12 percent worked in a job lasting or expected to last at least 3 months. Median income for this population was $475 during the month prior to completing the survey.[48]

Related Service Needs

Increasingly, people living with HIV/AIDS also have substance use or mental health issues that may or may not be combined with homelessness. People with both substance use issues and mental illness are at a greater risk for HIV/AIDS, are overrepresented in the homeless population, and experience more barriers to housing and health care. In a study published in 2001, 40 percent of people receiving HIV care reported using an illegal drug other than marijuana in the past 12 months, and 12 percent were found to be "drug dependent."[49] Thirty-one percent of people living with HIV/AIDS surveyed by AIDS Housing of Washington reported a disability related to substance use issues and 30 percent reported being disabled by mental illness.[50] Studies of various segments of the population with mental illness have found HIV prevalence rates ranging from 4 percent to 18 percent, compared to an estimated prevalence of 1 percent of the general population.[51]

Substance use and homelessness are also closely associated with incarceration and involvement with the criminal justice system. Particularly as people living with HIV/AIDS live longer lives, incarceration is a growing concern. The prevalence of AIDS among inmates is five times higher than that in the general population.[52] The Department of Justice found that female prisoners have a higher infection rate than male prisoners—4 percent versus 2 percent.[53] Having a criminal history can make a person ineligible for many types of housing and services, as well as limit employment opportunities. Among AHW survey respondents, 38 percent indicated they had been incarcerated at some point in their lives.[54]

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[47] National Coalition for the Homeless, *Rural Homelessness: NCH Fact Sheet #13*:, March 1999. Available online: http://www.nationalhomeless.org/rural.html (Accessed: September 19, 2003).

[48] Martha R. Burt et al., "1996 National Survey of Homeless Assistance Providers & Clients," in Patricia A. Post, M.P.A., *Hard to Reach: Rural Homelessness & Health Care*, National Health Care for the Homeless Council, January 2002, p. 8. Available online: http://www.nhchc.org/Publications/RuralHomeless.pdf (Accessed: September 19, 2003).

[49] Eric G. Bing, M.D., Ph.D., M.P.H. et al., "Psychiatric Disorders and Drug Use Among Human Immunodeficiency Virus-Infected Adults in the United States," *Archives of General Psychiatry*, vol. 58, no. 8 (August 2001), p. 721.

[50] AIDS Housing of Washington, *AHW Fact Sheet, Spring 2003: AIDS Housing Survey*. Available online: http://www.aidshousing.org/usr_doc/Survey_Factsheet_2003.pdf (Accessed: September 19, 2003). See footnote 44 of this document for list of areas represented.

[51] American Psychiatric Association, Office on HIV Psychiatry, "HIV Sero-Prevalence by Psychiatric Inpatient Setting: Summary of Studies," *HIV and People with Severe Mental Illness*, Slide 9, July 2002. Available online: http://www.psych.org/aids/modules/illness/sld009.htm (Accessed: September 19, 2003).

[52] National Commission on Correctional Health Care, "Chapter 3. Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," *The Health Status of Soon-to-be-Released Inmates: A Report to Congress*, *Volume 1,* p. 17. Available online: http://www.ncchc.org/stbr/Volume1/Chapter3.pdf (Accessed: September 19, 2003).

[53] Laura M. Maruschak, *Bureau of Justice Statistic Bulletin: HIV in Prisons, 2000*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, October 2002. NCJ196023. Available online: www.ojp.usdoj.gov/bjs/pub/pdf/hivp00.pdf (Accessed: September 19, 2003).

[54] AIDS Housing of Washington, *AHW Fact Sheet, Spring 2003: AIDS Housing Survey*. Available online: http://www.aidshousing.org/usr_doc/Survey_Factsheet_2003.pdf (Accessed: September 19, 2003). See footnote 44 of this document for list of areas represented.

Appropriate services and housing for people with histories of homelessness, mental illness, substance use, and/or incarceration can make a critical difference in improving health and quality of life. For example, housing stability is often necessary for a person living with HIV/AIDS to gain access to health care and adhere to treatment regimens. Individuals who have had histories of substance use, mental illness, and homelessness often need ongoing support services in order to maintain stable housing. People affected by these issues may need job skills training and ongoing support in order to obtain and maintain employment.

Homelessness in Nebraska

The state's Consolidated Plan, using a study completed in 1995, estimated that in a 12-month period there were 9,280 homeless people, including 5,080 adults and 4,200 children, as well as 319,250 people who were near homeless and required supportive housing, including individuals with histories of mental illness, substance abuse, and/or domestic violence as well as members of low-income households with housing needs.[55] A later report estimated that between May 2000 and May 2001, more than 19,600 people slept in homeless shelters for at least one night.[56] The Consolidated Plan estimated that of the 319,250 people who were not homeless but required supportive housing, 319 were living with HIV/AIDS.[57]

Funding for Homeless Services

The State of Nebraska provides funding for homeless services through the Nebraska Homeless Assistance Program (NHAP). Funding for this program comes from the federal Emergency Shelter Grant Program (ESGP) and the state Homeless Shelter Assistance Trust Fund (HSATF). ESGP funds are awarded to the state on a formula basis by the U.S. Department of Housing and Urban Development (HUD) and the state funds are created by a tax on the transfer of real estate in Nebraska. In 2002, a total of $2.29 million was awarded through NHAP.

The purpose of NHAP is to provide an overall "continuum of care" approach to address the needs of people who are homeless in Nebraska, by:

- Assisting in the alleviation of homelessness
- Providing temporary and/or permanent shelters for persons who are homeless
- Addressing the needs of migrant farm workers
- Encouraging the development of projects that link housing assistance programs with efforts to promote self-sufficiency

NHAP funds activities in four categories: facility operations, client services, homeless prevention, and facility rehabilitation. Funds are awarded through a regional and programmatic allocation process that emphasizes equitable distribution as well as quality projects and programs. Funding is granted to eligible community-based, neighborhood-based, and faith-based nonprofit organizations that provide emergency shelter and/or services for people who are homeless or near-homeless.

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[55] Nebraska Department of Economic Development, Division of Community and Rural Development, *2000–2005 Consolidated Plan: Housing and Community Development Programs*, part 4-23.
[56] University of Nebraska-Lincoln's Center for Applied Rural Innovation, *2001 Nebraska Housing Market Report*. Available online: crd.neded.org/housing/01hmr/index.html (Accessed: October 1, 2003).
[57] Nebraska Department of Economic Development, Division of Community and Rural Development, *2000–2005 Consolidated Plan: Housing and Community Development Program*, part 4-26.

Local Planning Processes Addressing Homelessness

The U.S. Department of Housing and Urban Development (HUD) provides funding for states and localities to address issues related to homelessness, primarily through the McKinney-Vento Homeless Assistance Act programs. Accessing funding through these programs requires that communities complete a Continuum of Care planning process, in which the resources available for people who are homeless are inventoried, and the unmet needs are quantified and prioritized. This approach helps communities plan for and provide a full range of emergency, transitional, and permanent housing and service resources to address the various needs of homeless persons. Designed to encourage localities to develop a coordinated and comprehensive long-term approach to homelessness, the Continuum of Care consolidates the planning, application, and reporting documents for many of HUD's homeless programs. All continuum of care regions in Nebraska, of which there are seven, submit Continuum of Care applications to HUD.

City of Omaha, Continuum of Care: Specific to people living with HIV/AIDS, the Omaha Continuum of Care estimated that were a total of twenty individuals living with HIV/AIDS, of whom nine were being served, leaving eleven in need. In addition, it was estimated that there were five people living with HIV/AIDS in families with children and that the current inventory to serve this population was zero. Both individuals living with HIV/AIDS and people living with HIV/AIDS in families with children were assigned a "low" priority in the process.

City of Lincoln, Continuum of Care: In 1996, the City of Lincoln began receiving ESGP funds and administering local allocations of the Nebraska Homeless Assistance Trust Fund. For this reason, the City of Lincoln's Urban Development Department led the community through a Continuum of Care planning process.[58] Based on data from three of the city's emergency shelters, the homeless population of Lincoln in 1995 was estimated at close to 3,000, of which 49 percent were male, 20 percent were female, and 31 percent were children.[59] The housing needs of people living with HIV/AIDS were estimated. It was projected that a total of five single people living with HIV/AIDS were in need of transitional housing. At that time, there were no dedicated transitional housing programs for this population.[60]

City of Lincoln, Consolidated Plan: The City of Lincoln's *Consolidated Plan FY 2000–FY 2003* includes a section addressing homelessness and the city's Continuum of Care. It estimates that 1,700 people were homeless or "imminently homeless" in Lincoln on any given day, including 758 single individuals and 980 people in families with children.[61] It also estimates that there are eight homeless individuals living with HIV/AIDS, for whom there are five beds, leaving a three-person gap. Additionally, it estimates that there are no people in families living with HIV/AIDS, no units to serve them, and, therefore, no unmet need. Both groups were assigned a "low" priority in the Continuum of Care.[62] However, the Consolidated Plan also estimates that there are an additional 1,468 non-homeless people in subpopulations with special needs in need of housing assistance, including 75 people living with HIV/AIDS. A "medium" priority was assigned to this population. Providing services for this population would require $11,250,000 in funding.[63]

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[58] City of Lincoln, Nebraska, Community Development Division, Urban Development Department, *Consolidated Plan FY 2000–2003 for HUD Entitlement Programs*, p. 1.
[59] Ibid., p. 5.
[60] Ibid., p. 33.
[61] City of Lincoln, Nebraska, Community Development Division, Urban Development Department, *Consolidated Plan FY 2000–2003 for HUD Entitlement Programs*, p. VI-2.
[62] Ibid., Appendix A, Table 1A, p. A-1.
[63] Ibid., Appendix A, Table 1B, p. A-2.

HIV/AIDS-Dedicated Resources

The AIDS housing continuum has developed over time to meet the changing housing needs of people living with HIV/AIDS. Federal programs have been implemented to fund housing and related support services for people living with HIV/AIDS.

- In June 2003, the Nebraska Department of Health and Human Services partnered with the Nebraska AIDS Project and other community stakeholders to submit an application for HOPWA Competitive funds. The application proposed a range of housing initiatives.
- In Nebraska, the Ryan White CARE Act Title II program funds limited housing and related support services.

The following pages present an overview of HIV/AIDS housing and information regarding the primary federal sources of funding involved in housing people living with HIV/AIDS, including the Housing Opportunities for Persons with AIDS and the Ryan White CARE Act programs. In addition, information about a private source of funding, the Flowers Fund, is presented.

HIV/AIDS-Dedicated Resources in the National Context

No specific funding dedicated to AIDS housing existed prior to 1990. Local corporations, foundations, churches and faith-based communities, generous individuals, local governments, and significant volunteer labor drove the creation of early housing projects. Much of the development and provision of AIDS housing has since shifted to mainstream affordable and supportive housing providers, as well as public housing authorities and local governments.

The federal government has established two programs that now provide funding dedicated to serving people living with HIV/AIDS—the Housing Opportunities for Persons with AIDS (HOPWA) program administered by the U.S. Department of Housing and Urban Development (HUD) and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act program administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). Both can be used to fund housing supports, although the eligible activities differ between programs.

Many AIDS housing and service providers rely on funding from HOPWA and the Ryan White CARE Act to support their programs. The first phase of a Vanderbilt University AIDS housing cost study determined that 66 percent of the nation's AIDS housing providers received HOPWA funding for AIDS housing and services, while 55 percent received CARE Act funds. These two funding sources are extremely important to the ability of these agencies to provide AIDS housing and are often used in tandem—44 percent of AIDS housing providers indicated that they receive funding from both HOPWA and Ryan White CARE Act.[64]

These essential resources assist communities to meet the housing needs of people living with HIV/AIDS; however, they can only meet a portion of the need. Other federal programs that provide

[64] Debra Rog and Sidra Goldwater, *The Landscape of AIDS Housing*, Vanderbilt University, Washington, DC, 1999.

funding for housing low-income people, regardless of HIV status, are essential to creating the safety network many people rely on. These programs will be described in ***Appendix VI***.

Housing Opportunities for Persons with AIDS (HOPWA)

Since 1992, the federal government has allocated more than $1.7 billion for the HOPWA program to support community efforts to create and operate HIV/AIDS housing and provide related services.[65] In the first year of the program, 27 eligible metropolitan statistical areas (EMAs or EMSAs) and 11 eligible states received formula allocations of $42.9 million. By FY 2003, $259 million in HOPWA funds was available for formula allocations and competitive awards. A total of 111 jurisdictions—75 metropolitan areas and 36 states—received formula allocations in 2003.[66]

HOPWA provides grant funds to state and local governments to design long-term, comprehensive strategies for meeting the housing needs of people living with HIV/AIDS and their families. Participating jurisdictions have the flexibility to provide a range of housing assistance, including:

- Housing information services
- Project- or tenant-based rental assistance
- Short-term rent, mortgage, and utility payments to prevent homelessness
- Housing development
- Support services

Ninety percent of HOPWA funds are awarded through formula grants. The remaining 10 percent are awarded through a competitive grant program.

Eligible metropolitan statistical areas (EMSAs) and states receive direct allocations of HOPWA funding when 1,500 cumulative cases of AIDS are diagnosed in a specific geographic region. A total of 111 jurisdictions—75 metropolitan areas and 36 states—received formula allocations in 2003.[67] Because 1,236 cases of AIDS had been diagnosed in Nebraska by the end of 2002, the state has not met the threshold to receive a HOPWA formula grant. However, agencies in Nebraska are eligible to apply for funding through HOPWA's Competitive Program.

In June 2003, Nebraska Department of Health and Human Services, in partnership with the Nebraska AIDS Project and other community partners, submitted an application to HUD for funding under the HOPWA Competitive Program. The application proposed a range of programs to support people living with HIV/AIDS to access and maintain permanent housing, including long-term rental assistance, short-term rent, mortgage, and utility assistance, housing information, and related support services.

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[65] U.S. Department of Housing and Urban Development, Office of HIV/AIDS Housing, *Housing Opportunities for Persons with AIDS: Community Collaborations to Provide Housing and Related Services for Persons who are living with HIV or AIDS and their families*, Fact Sheet, April 2002. Available online: http://www.hud.gov/offices/cpd/aidshousing/programs/factsheet.pdf (Accessed: October 1, 2003).

[66] U.S. Department of Housing and Urban Development, Office of HIV/AIDS Housing, *Housing Opportunities for Persons with AIDS (HOPWA)*, fact sheet. Available online: www.hud.gov/offices/cpd/about/budget/budget03/index.cfm (Accessed: October 1, 2003).

[67] U.S. Department of Housing and Urban Development, Community Planning and Development, *FY 2003 HOPWA Formula Allocations*, March 3, 2003. Available online: http://www.hud.gov/offices/cpd/aidshousing/programs/formula/grants/2003.pdf (Accessed: October 1, 2003).

Ryan White CARE Act

The Ryan White CARE Act was first authorized in 1990 to address the full range of unmet health needs of people living with HIV/AIDS by funding primary health care and related support services, and increasing access to care for underserved populations. In fiscal year 2002, Congress appropriated $1.9 billion for use under the CARE Act, which serves more than 500,000 individuals each year.[68]

Ryan White CARE Act Title II program funds are awarded to all states based on a formula. Title II funds are for services for people living with HIV/AIDS and for state AIDS Drug Assistance Programs (ADAP). In Nebraska, Title II funds are utilized to provide individuals living with HIV disease economic assistance for rent, utilities, transportation, health insurance, food, and nutritional supplements. Title III health care and health care-related services are offered through the University of Nebraska Medical Center in Omaha, which provides services to the eastern two-thirds of the state, and Western Community Health Resources, located in Chadron, which provides services in the panhandle region of western Nebraska. Together, these services allow individuals who do not qualify for Medicaid, Medicare, or private insurance to access needed services.[69]

Table 7 presents Nebraska's total Ryan White Title II grant award for three fiscal years, as well as expenditures in housing-related categories.

Table 7:
Nebraska Ryan White Title II Expenditures Per Housing-Related Activity, FY 2000–2002

Activity	FY 2000	FY 2001	FY 2002
Total Grant	**$1,609,180**	**$1,753,980**	**$1,946,912**
Housing	$98,502	$85,255	$103,204
Utilities	$35,630	$23,130	$31,110
Case Management	$156,545	$206,000	$221,982

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, January 29, 2003.

Note: FY 2002 expenditures are projections from January 2003 for the end of the fiscal year. Total grant amount includes the Title II Award, the state's ADAP contribution, prior year carryover, and, for FY 2001 and FY 2002, a supplemental ADAP award.

Ryan White Title I funds are awarded to metropolitan areas of over 500,000 people with at least 2,000 AIDS cases in the preceding five years. As no metropolitan area in Nebraska meets these criteria, no Title I funds are granted to Nebraska.

[68] U.S. Department of Health and Human Services, Health Resources and Services Administration, *The AIDS Epidemic and the Ryan White CARE Act: Past Progress, Future Challenges 2002–2003*. Available online: ftp.hrsa.gov/hab/fundinghistory.pdf (Accessed: October 1, 2003).

[69] Nebraska Department of Health and Human Services, *Ryan White Program*. Available online: www.hhs.state.ne.us/dpc/ryan%5Fwhite.htm (Accessed: October 1, 2003).

Nebraska AIDS Project

The Nebraska AIDS Project (NAP) is the only AIDS service organization in Nebraska. Founded in 1984, NAP provides a range of services to people living with HIV/AIDS in Nebraska, southwest Iowa, and eastern Wyoming, including case management, support groups, education and prevention, HIV counseling and testing, Nebraska AIDS Hotline, and programs for priority populations. Case management and other support services are available to people living with HIV/AIDS through five offices located in Kearney, Lincoln, Norfolk, Omaha, and Scottsbluff. The Watanabe Wellness Center is located in Omaha and provides clients access to a resource center for AIDS-related issues, mental health services, breakfasts, lunches, massage, and other complimentary therapies. In 2002, a total of 723 unduplicated clients were served through NAP programs.[70]

The Flowers Fund

There is another small source of funding specifically to assist people living with HIV/AIDS in Nebraska, called the Flowers Fund, which is supported by private fundraising in the gay, lesbian, bisexual, and transgender community. This fund was developed before Ryan White funds were available in the state. Guidelines include funding activities beyond Ryan White coverage. Funding is typically given as a grant rather than a loan. There is a $350 cap per client per year. The Nebraska AIDS Project typically accesses $1,000 to $1,500 in assistance for its clients from this fund every year, depending on the need. In addition, the community members behind the Flowers Fund also conduct annual Thanksgiving dinner and Christmas gift drives for people living with HIV/AIDS who are identified as having a need.[71]

[70] Nebraska AIDS Project, email communication with AHW staff, April 1, 2003.
[71] Nebraska AIDS Project, email communication with AHW staff, January 31, 2003.

Survey Findings

The following pages present findings from a statewide HIV/AIDS housing needs assessment survey conducted by the Nebraska Department of Health and Human Services in 2002. Key findings include:

- Survey respondents resembled reported cases of HIV/AIDS in Nebraska in terms of gender and race/ethnicity.
- Respondents lived in twenty-five of Nebraska's ninety-three counties.
- More than one-third had first tested positive for HIV in the past five years.
- More than a quarter had incomes less than $500 per month, which is below poverty level.
- The vast majority lived alone.
- Slightly more than one-third of respondents were "severely rent burdened," paying more than half of their income for housing.
- Fifteen percent had faced eviction in the past year, and 39 percent had been homeless since testing positive for HIV.
- Just 12 percent had regular assistance paying their housing costs.

The following pages present findings from the Nebraska HIV/AIDS 2002 Statewide AIDS Housing Needs Assessment survey of people living with HIV/AIDS in Nebraska. This survey was conducted by the Nebraska Department of Health and Human Services (NHHS) and the Nebraska AIDS Project (NAP), and completed by February 25, 2002.

Additional information is included from the Ryan White Services Client Satisfaction Survey, conducted in 2001 by the Ryan White Title II program for Titles II and III.

Statewide AIDS Housing Needs Assessment Survey Respondents

The survey was distributed primarily to people receiving HIV-related care or services and therefore it is likely that most respondents were accessing services of some type. The survey pool represented approximately 19 percent of the 1,112 individuals reported to be living with HIV or AIDS in Nebraska. Compared to the demographic profile of those reported to be living with HIV and AIDS in the state, survey respondents resembled reported cases in terms of gender and race/ethnicity. The ages of survey respondents were generally higher than the ages of reported HIV and AIDS cases. One reason for this is that case ages represent the age at diagnosis, and survey respondent ages represent age at the time of the survey.

Table 8 compares the demographic profiles of survey respondents and people living with HIV/AIDS as of December 2002.

Table 8:
Survey Respondents Compared to People Living with HIV/AIDS in Nebraska

Demographics	Survey Respondents		People Living with HIV/AIDS (12/31/02)	
	Number	**Percent**	**Number**	**Percent**
Race/Ethnicity				
White/Caucasian	150	70%	678	61%
Black	43	20%	265	24%
Hispanic	19	9%	134	12%
Native American	*	1%	24	2%
Asian/Pacific Islander	—	—	7	1%
Multi-racial	—	—	NA	NA
Other	*	1%	4	<1%
Total	**215**	**100%**	**1,112**	**100%**
Gender				
Male	158	74%	879	79%
Female	49	23%	233	21%
Total	**215**	**100%**	**1,112**	**100%**
Age++	**At Survey Completion**		**At Diagnosis**	
Under 20 years	*	1%	31	3%
20 to 29 years	20	9%	318	29%
30 to 39 years	77	36%	495	45%
40 to 49 years	74	34%	202	18%
50 and older	NA	NA	66	6%
50 to 59 years	25	12%	NA	NA
60 years and over	10	5%	NA	NA
Total	**215**	**100%**	**1,112**	**100%**

Source: Nebraska Department of Health and Human Services, email communication with AHW staff, February 6, 2003.

Note: AIDS data includes cases reported January 1983 through December 2002. HIV data includes cases reported July 1995 through December 2002. Numbers may not total 215 in survey respondent demographic categories because respondents may have skipped questions. Some data has been combined.

*Total number of respondents is three or less. Numbers less than 4 are not entered to protect the privacy of individuals with HIV/AIDS. Percents may not total 100 due to rounding.

++HIV and AIDS epidemiology statistics use different age categories than those included on the survey. Age categories here are under 20, 20 to 29, 30 to 39, 40 to 49, and 50 and older (which includes survey respondents aged 50 to 59 years and 60 years and over).

Summary of Findings

Demographics

Seventy-five percent of survey respondents were men, which is reflective of the population of people known to be living with HIV/AIDS in Nebraska. The majority of respondents—about two-thirds—were single adults with no children. However, nearly one in five was a single adult with a child or children. Approximately two-thirds were aged 30 to 49 years old.

Survey respondents in twenty-five of Nebraska's counties participated. Douglas County had the largest number of respondents, with more than half of the total. The second most commonly reported county was Lancaster, with 13 percent of the total. Buffalo and Hall Counties each had 4 percent, while Scotts Bluff had 3 percent and Madison had 2 percent. An additional nineteen counties each had 1 percent of respondents.

HIV/AIDS Status

More than a third (37 percent) had tested positive for HIV within the past five years (1998 to 2002). More than two-thirds first tested positive in Nebraska. The next most frequently reported states were Texas, California, and Iowa.

Respondents were asked how many times they had been hospitalized for HIV/AIDS-related reasons both since testing positive and in 2001. More than half had never been hospitalized, and more than a quarter (29 percent) had been hospitalized once or twice, leaving less than a quarter who had been hospitalized three or more times. Similarly, 79 percent had not been hospitalized in 2001. Five percent had been hospitalized three or more times in 2001.

Income

Respondents were asked to report their income based on given ranges of income. The majority of survey respondents had incomes below $1,000 per month, with more than a quarter (28 percent) having incomes below $500 per month. The most common source of income was Social Security Disability Income (SSDI), reported by one-third of respondents. The next most common was full-time employment, reported by nearly a quarter.

Current Housing

The most common household type reported was people living alone. The vast majority—81 percent—reported being the only person in their home. Just 11 respondents, or 5 percent, reported having anyone younger than 18 in their household.

The most common housing type was renting an apartment, reported by 45 percent of respondents. However, 18 percent of respondents owned their own homes. Living with friends or relatives was the third most commonly reported housing situation.

Respondents were asked to report the amount they paid for housing costs, including utilities. The median amount reported was $400, meaning half of respondents paid more and half paid less. The least reported was $0 and the most was $3,400. The majority (56 percent) paid $500 or less for housing, including 12 percent who paid nothing. More than a quarter (28 percent) paid $501 to $750 for housing.

Respondents were also asked to estimate the percentage of their income paid toward housing costs. The U.S. Department of Housing and Urban Development has set 30 percent of gross income as the limit for "affordable" housing payments, meaning that housing which costs 30 percent of gross income or less is affordable, and housing which costs more is not. Renters paying more than 30 percent are considered to be "rent burdened," while renters paying more than 50 percent are considered "severely rent burdened." Forty percent of respondents reported paying 30 percent or less of their income for rent, meaning that their rent is affordable. Less than a quarter (23 percent) were paying 31 to 50 percent, meaning that they were rent burdened, and slightly more than one-third (36 percent) were severely rent burdened, paying more than half their gross income for rent.

Housing and Homelessness History

Respondents were asked whether they had experienced a selected set of housing situations within the last 12 months. For a complete list of situations given, see ***Appendix III***. Generally, financial problems were reported more commonly than other situations. Specifically:

- 33 percent had needed financial assistance to prevent heat or utilities from being cut off
- 28 percent had needed financial assistance to prevent homelessness
- 22 percent had their phone service cut off
- 14 percent had their heat or utilities cut off
- 10 percent had moved because they could not pay rent

Respondents reported a variety of strategies to cope with housing difficulties. Those most commonly reported included:

- 23 percent moved in with friends or relatives
- 19 percent let other people move in to help pay expenses
- 18 percent had to sell their car or other personal belongings to pay expenses

A total of 15 percent of respondents had faced eviction within the last twelve months. Eviction is generally considered the most serious housing problem a person can have, and people facing eviction are at high risk of homelessness. More than a third (39 percent) reported that they had experienced homelessness since testing positive for HIV, including experiences living in a car, a park, a homeless shelter, a motel, and/or doubled up with friends or relatives, among others.

Fourteen percent reported having been discriminated against in housing based on their sexual orientation. More than a third (39 percent) believed it would jeopardize their housing if they disclosed their HIV status to their landlord, mortgage company, or housing provider.

Housing Assistance

More than a third (39 percent) had tried to access housing assistance through a housing authority or other housing provider. Just 12 percent reported having assistance from a housing authority or other organization with paying rent on an ongoing basis. Another 4 percent were on a waiting list for assistance.

One question on the Client Satisfaction survey asked specifically about "services." More than a quarter (26 percent) of respondents had received assistance with their utilities from a case manager within the past year, and 22 percent with housing.

Access to Support Services

Transportation connects people to support services and medical care. Respondents were asked about the modes of transportation available to them. Half had a functional vehicle, typically the most flexible and convenient transportation option, while 11 percent reported a car not functioning due to repair needs. Less than a quarter (22 percent) had access to public transportation. Eighteen percent had access to transportation only through a friend, an option that requires maintaining the friendship as well as the car. Some (7 percent) had access to transportation only through a case manager.

Respondents were asked whether they had ever tried to access mental health services. Of the 86 (40 percent) who had, all but 12 had been able to access it. Most of those who could not (8) were put on a waiting list. In the Ryan White Services Client Satisfaction Survey, 38 percent reported they did not need mental health services, and 43 percent reported they were able to access mental health services in their area without any trouble. Ten percent "somewhat agreed" that they could easily access mental health services in their area, while 9 percent disagreed.

A much smaller proportion—15 percent—reported having tried to access substance abuse services. Nearly all, 28 of 32, reported success in accessing services. Seven reported having been put on a waiting list, for 14 days up to 20 months. The Client Satisfaction survey also asked about experience accessing substance use treatment services. Three-quarters of respondents reported they did not need these services, or that these services did not apply to them. Thirteen percent agreed they accessed these services without trouble, and 5 percent somewhat agreed. Seven percent disagreed with the statement that they could access services without trouble.

Those survey respondents who had tried to access substance abuse services reported a much higher frequency of housing problems. Specifically, they were more likely to have stayed in a shelter in the last twelve months, spent more than one night sleeping in a car or the street, been in jail or prison, or faced eviction.

Consumer Focus Group Findings

A total of 38 people living with HIV/AIDS in Nebraska participated in consumer focus groups. Key findings include:

- People living with HIV/AIDS throughout Nebraska, and especially in rural communities, face significant stigma and discrimination related to their HIV status. Many people fear disclosure and are concerned for their personal safety.
- Safe, decent, and affordable housing is very difficult to secure and maintain, particularly for people living on very low incomes.
- People living with HIV/AIDS experience barriers to housing stability and access to services that affect their quality of life.
- Focus group participants indicated that support from friends, family, service providers, and other people living with HIV/AIDS is important and increases their quality of life.
- The combination of these issues creates specific and unique challenges for residents of rural areas.
- People living with HIV/AIDS who participated in focus groups shared many suggestions about the kind of housing and services that would be the most helpful.

Overview of Focus Groups

Focus groups are an important way to obtain input from people living with HIV/AIDS in the needs assessment process. Meeting in small groups with other HIV-positive people, as opposed to participating in a public meeting or completing a survey, allowed participants the opportunity to discuss a range of issues related to their housing situations, needs, and preferences in more detail. While participants in each group were asked similar questions, individuals in each group shaped the conversation by highlighting those issues of greatest concern to them.

Participants received $10 in cash for their participation. The Nebraska AIDS Project organized the focus groups and invited clients to participate in the groups. A total of eight focus groups were held in the following communities (number of participants in parenthesis):

- Fremont (no participants)
- Lincoln (2 participants)
- Norfolk (3 participants)
- North Platte (1 participant)
- Kearney (5 participants)
- Omaha (2 groups, 22 participants)
- Scottsbluff (5 participants)

Steering Committee members noted that while there was low participation in some of the focus groups, they did not believe that increased participation would have resulted in additional findings or the identification of different critical issues.

Issues Identified by Focus Group Participants

People living with HIV/AIDS who participated in the focus groups had a wide variety of experiences and needs, as well as opinions about the kind of housing and services that would be helpful for them personally and for people living with HIV/AIDS in general. Some common themes and ideas emerged, and are presented here. Each focus group is summarized separately in ***Appendix V.***

People living with HIV/AIDS throughout Nebraska, and especially in rural communities, face significant stigma and discrimination related to their HIV status. Many people fear disclosure and are concerned for their personal safety.

In almost every focus group, people living with HIV/AIDS talked about stigma related to being HIV-positive and shared stories of discrimination they had experienced or were familiar with. The extent to which concerns about stigma, discrimination, and personal safety were raised by focus group participants cannot be overemphasized.

~

"People may know you have HIV and you're never sure how, or what they know, or how they are going to treat you."

Focus Group Participant

~

- People **fear losing their jobs, housing, social standing, and friends** if their HIV status were to become known. While individuals sick with cancer or other illnesses receive support from their work colleagues, it was generally agreed that an HIV-related illness would horrify workmates and that the infected person would be ostracized. People reported instances of being evicted when their landlord found out they were HIV-positive. Focus group participants were concerned about how the perceptions of their neighbors and colleagues could affect how they are treated and accepted in the community. One focus group participant wondered, "what if they (a) don't hire me, (b) treat my kids poorly, (c) don't let me rent from them." Participants related stories of people in their communities who were treated poorly because others thought they were HIV-positive. However, one participant indicated that if people are involved and well-known within their community, social relationships are less negatively impacted if their HIV status becomes known.
- People **fear for their physical safety**. Participants indicated that they had experienced assaults, threats, and intimidation because of their HIV status. One participant talked about having his/her car shot at. Another participant related the story of a sheriff in a small community killing the dog of a gay HIV-positive couple as a message that the couple was not welcome in the town.
- Focus group participants believed that **general community members need education.** It is assumed that community members are scared of HIV disease and that HIV is treated differently from other illnesses. The conservative nature of some communities makes social support and understanding of HIV disease a challenge. A number of focus group participants remarked that if a person is known to be HIV-positive, people assume the person is gay, and if a person is known to be gay, community members assume that person is HIV-positive. This connection is widely believed and makes even social relationships challenging.

Safe, decent, and affordable housing is very difficult to secure and maintain, particularly for people living on very low incomes.

It is difficult for people living on low incomes to afford housing of good quality. Focus group participants from throughout the state spoke of the challenges they have experienced finding and maintaining housing. Some of the issues discussed included:

- There is limited **availability** of appropriate housing affordable to low-income people generally.
- For **those who are already housed**, meeting monthly housing expenses can be a burden.
- In many parts of the state, much of the affordable housing is of **substandard quality.** The health and safety of these housing units is in question. Many would not be appropriate for use with federal housing subsidies such as the Housing Choice Voucher program because they would not pass the necessary inspection.

~

"Imagine how many people have struggled and strived for assistance."

Focus Group Participant

~

- There is concern that low-cost housing is concentrated in **less desirable neighborhoods** and locations, where drug use, criminal activity, and/or availability of necessary services are issues of concern.
- **People value confidentiality and fear discrimination in housing.** Some individuals have been evicted from housing when the landlord became aware of their HIV status, and others avoid raising housing-related issues with roommates and landlords because they fear they will lose their housing.
- Focus group participants identified **other barriers to accessing affordable housing.** Some landlords discriminate based on source of income and are reluctant to accept a tenant who receives General Assistance or other financial support. A person with poor and/or no credit or a criminal history may be screened out by background checks conducted by a prospective landlord. Security deposits and move-in costs can be a significant financial burden. Racial discrimination is a factor for some people.

People living with HIV/AIDS experience barriers to housing stability and access to services that affect their quality of life.

One of the primary barriers identified by people living with HIV/AIDS was the **lack of adequate public transportation.** Even in Omaha, which was identified as having the best public transportation, focus group participants identified the lack of reliable transportation as a significant barrier to housing stability and access to services. For residents of smaller towns and rural communities, the lack of public transportation is an issue that impacts life every day.

Some people travel hundreds of miles to **access medical care and social services**. In some communities, local medical providers have denied general medical care to HIV-positive individuals due to their HIV status alone. Access to medical care is impacted by the distances people need to travel for care, and is further restricted for individuals who have limited or no health insurance.

~

"You can sleep in your car, but you can't drive your house."

Focus Group Participant

~

Other issues were also identified by focus group participants. The importance of having **adequate food** and proper nutrition was highlighted. Participants also discussed their perception that there are **language barriers** for Sudanese and monolingual Spanish speakers.

Focus group participants indicated that support from friends, family, service providers, and other people living with HIV/AIDS is important and increases their quality of life.

People living with HIV/AIDS want and need support from family members, service providers, and each other. However, concerns about stigma and confidentiality, combined with geographic and transportation barriers, impact how and when people come together for support or services. Many people move to or remain in communities because family members are close by. Some focus group participants indicated that **informal support networks** have developed among people who are connected to services and those who are not.

The combination of these issues creates specific and unique challenges for residents of rural areas.

The issues discussed previously impact all residents of Nebraska who are living with HIV/AIDS. However, for residents of rural areas **each of these issues is amplified by the nature of life in small towns and rural communities.** For a resident of a rural community in western Nebraska, traveling 50, 100, or 150 miles to get to the doctor or grocery store is common. In rural areas even "next-door neighbors" can be quite far away. The lack of knowledge about HIV and other health matters on the part of many rural community members and the lack of interest in addressing these issues directly help foster an environment of stigma and fear that impacts the availability of social interaction and support for HIV-positive residents.

One focus group participant related a story that exemplifies how these challenges combine for an HIV-positive resident of a rural community living on a low income. Community members know that this individual is HIV-positive. When the participant needs groceries, s/he must decide whether to go to the local grocery store, which would require paying attention to the fears and/or disapproval of fellow shoppers, or travel to the grocery store in the next county, which would require more time and resources. The simple act of going to the store requires a significant amount of deliberation and extra energy for this HIV-positive person.

People living with HIV/AIDS who participated in focus groups shared many suggestions about the kind of housing and services that would be the most helpful.

Participants were asked about the types of housing assistance or other services they thought would be most helpful for people living with HIV/AIDS. Participants had a wide variety of suggestions and comments, all of which are included in focus group summaries in Appendix V. Themes that emerged across the focus groups included the following:

- There was general consensus among focus group participants that HIV-dedicated housing facilities should not be developed. Participants in rural areas were especially clear that HIV-dedicated housing is not a desirable option and in fact would create serious problems.
- Safe, decent, and affordable housing options that are not identified as housing for people living with HIV/AIDS should be available in various neighborhoods and communities. Scattered-site housing, mixed-use housing, and rental assistance would allow for flexibility, choice, and privacy.

- Housing assistance programs should be developed to assist people living with HIV/AIDS to remain in their current housing. This would include short- and long-term programs.
- People would benefit from the assistance of a staff person who is dedicated to assisting people to find housing.
- It was suggested that a resource guide be developed to clearly articulate available services, eligibility criteria, program guidelines, etc.
- Additional services would increase the quality of life and support the housing stability of people living with HIV/AIDS, including access to food vouchers, education, money management skills development, and information about Medicaid spend-down.

~

"You need support to be able to get housing."

Focus Group Participant

~

Key Stakeholder Interview Findings

Interviews were held with key stakeholders from throughout Nebraska. A total of 76 people participated in the needs assessment through key stakeholder interviews. Key findings include:

- The primary barrier to finding and maintaining stable housing is the lack of safe, affordable housing units, in both rural and urban areas. Housing authorities around the state are the primary provider of affordable housing and the availability of their resources varies.
- Stigma and discrimination significantly influence how, where, and when people living with HIV/AIDS reach out for assistance with housing and services needs.
- Across rural areas, small towns, and urban centers, transportation barriers permeate every aspect of service delivery and access to housing.
- Funding for important support services, such as mental health and substance use treatment, is in jeopardy as the state legislature contemplates significant budget cuts.
- Increased collaboration and partnerships are needed among housing and service providers to ensure that stronger, more effective community networks are available to serve people living with HIV/AIDS throughout Nebraska.
- The growing population of immigrants in Nebraska is experiencing multiple barriers to housing and services, including documentation requirements and a lack of translation services.

Overview of Key Stakeholder Interviews

HIV/AIDS service providers, health-care providers, housing providers and advocates, government representatives, and others participated in the needs assessment process through key stakeholder interviews. Interviews were conducted in person and by phone from February 2003 through May 2003. A total of 76 stakeholders from throughout Nebraska were interviewed. On-site interviews were held in Fremont, Norfolk, Omaha, Lincoln, Grand Island, Kearney, North Platte, and Scottsbluff. A list of these individuals and their agency affiliations can be found at the beginning of this document.

Findings from Key Stakeholder Interviews

Key stakeholders identified issues related to the availability of affordable decent housing, stigma and confidentiality, transportation barriers, related support services, collaboration among community agencies, and immigrant populations. Themes emerging from the interviews are summarized below.

The primary barrier to finding and maintaining stable housing is the lack of safe, affordable housing units, in both rural and urban areas. Housing authorities around the state are the primary provider of affordable housing and the availability of their resources varies.

In every community where interviews took place, stakeholders identified **the lack of affordable, decent, and safe housing stock as the primary housing barrier** for all people with low incomes. People who are not able to afford decent units end up living in substandard units, doubling up with

family or friends, or relying on emergency shelters, if available. Many key stakeholders believe that much of the affordable housing available is of poor quality, particularly in urban areas. Availability of any type of rental housing in rural areas is very limited. Even those people who do find an appropriate, affordable unit to rent must have the resources to pay security deposits and other move-in costs. Affordability issues are complicated by a lack of living-wage jobs throughout the state.

The demand for subsidized housing resources exceeds the available inventory. Housing authorities provide the majority of subsidized housing in Nebraska, mostly through the Housing Choice Voucher (Section 8) and public housing programs. Key stakeholders reported that most housing authorities have a waiting list for Section 8 vouchers. In Lincoln, for example, 1,800 people are on the waiting list and the Housing Authority has issued more vouchers than they can subsidize. No new vouchers will be issued, although the waiting list remains open. Information about the application process is not always clearly communicated. Those who receive a Section 8 voucher sometimes have difficulty finding a landlord willing to work with the program. In college towns, such as Hastings and Kearney, landlords rely on students to fill their rental units and are therefore less likely to rent to people with subsidies. One housing authority representative identified families in transition as a particularly difficult population to serve.

In addition, the public housing stock is old and in need of updating, and some stakeholders felt the **present environments are not healthy for people living with HIV/AIDS**. Key stakeholders expressed concern over violence, substance use, and confidentiality in public housing units. Stakeholders identified few housing options for people living alone as well as undocumented immigrants. **Other identified barriers** to finding and maintaining stable housing included criminal history, poor credit, and poor rental history.

Some **key stakeholders questioned the definition of affordability** and said that calculations for Fair Market Rents (FMRs) are set too low for the existing market. Vouchers do not make up the difference between FMR and market rent. This is especially difficult for people living on SSI (Supplemental Security Income) and others whose income is below the poverty line. In other cases, the eligibility requirements of programs designed to help families become self-sufficient might have the unintended impact of decreasing housing stability. In Lincoln, for example, as part of the Moving to Work program, families with subsidized housing are required to count all household residents over age 19 as working 25 hours a week or more, whether or not they really are employed. The result is that a rent increase may be beyond the real family income, and, in some cases, young adults over the age of 19 may be required to move out.

Key stakeholders indicated that another factor in the affordability calculation is **property taxes** paid by the owners of multifamily rental housing. Low-income units are taxed at the same rate as market-rate units. There is no property-tax-related incentive for developers to target their units to low-income people. One key stakeholder in Grand Island indicated that this factor decreases the likelihood that new developments will target low-income persons. Steering Committee members noted that recent state legislation changed property tax provisions to exempt certain housing developments from some taxes.

Key stakeholders discussed an **overall lack of community leadership and political will** for developing supportive housing. Some stakeholders felt there were private developers interested in creating more housing, but their experience operating housing units was limited. One stakeholder said there is a gap in knowledge about low-income housing development and an ongoing need for more assessment and planning.

It is estimated that there are more than 9,200 homeless individuals in Nebraska over the course of a year, and many more state residents require support to remain stably housed.[72] The State of Nebraska provides **funding for homeless services** through the Nebraska Homeless Assistance Program using a combination of federal and state funds. The state funding comes from a tax on the transfer of real estate in Nebraska. The dedication of these state funds helps provide a solid framework for the provision of services to homeless people and clearly is a strength of the system. However, providers in most parts of the state do not access federal Continuum of Care funding. Providers expressed a desire for increased coordination of homeless activities and formalization of relationships within the continuum of care. Additionally, issues related to securing a location for a project and community support were identified as barriers to developing housing. Stakeholders gave examples of NIMBY-ism in both Lincoln and North Platte.

Stigma and discrimination significantly influence how, where, and when people living with HIV/AIDS reach out for assistance with housing and services needs.

Across Nebraska, many people living with HIV/AIDS continue to hide their health status in fear of the negative impact disclosure may have on their families, employment, health insurance, housing, and physical safety. Several key stakeholders addressed the issues of **stigma and discrimination** and how these factors keep individuals from reaching out for support and assistance, especially people living in smaller communities, rural settings, and culturally-based communities. One case manager described the difficulty of keeping HIV status confidential in a small town; many of the individuals she works with do not want to receive services at the local clinic. Stakeholders indicated that people are willing to travel long distances, even out of state, for care, in order to protect their confidentiality as well as to find providers with whom they feel comfortable.

~

"Stigma is a thousand-pound gorilla that most of us carry around, even providers."

Key Stakeholder

~

Key stakeholders discussed the overall lack of understanding by policymakers and the general public about HIV/AIDS, which perpetuates the notion that **HIV/AIDS is not present in some communities**. The disease continues to be associated with gay men and is viewed as a moral issue. There is an overwhelming perception that disclosure of status, even within personal networks, such as congregations or in smaller communities, may not be well received. Some members of the Steering Committee noted that as more people from rural areas move to Lincoln and Omaha, these urban communities are being influenced by more conservative opinions.

A number of key stakeholders identified some of the **cultural factors** that contribute to feelings of isolation and reluctance to seek support by people living with HIV/AIDS. A high level of stigma within Somali and Sudanese cultures means people living with HIV/AIDS fear losing family support and cultural connection if their infection becomes known. The same was expressed about Latinos who fear the possibility of losing their personal support networks if their status is revealed. Many Native Americans are also cut off from their communities and culture when seeking services. For Native Americans living on reservations, stigma can be a significant barrier, as well as other issues such as poverty, lack of health care, and alcoholism.

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[72] Nebraska Department of Economic Development, Division of Community and Rural Development, *2000–2005 Consolidated Plan: Housing and Community Development Programs*, part 4-23.

Stakeholders reported that individuals with HIV/AIDS have expressed concern over **confidentiality in living environments**. For example, some feel pressured by landlords to disclose disability information, especially after periods of illness. Providers in different communities shared stories of tenants being evicted once a landlord learned of their HIV status, and of individuals unwilling to file discrimination complaints because of confidentiality. Other issues were fear of disclosure to public housing authorities and the possibility of neighbors in public housing becoming aware of a resident's HIV status. Steering Committee members noted that federal law requires that most personal information provided to housing authorities by applicants and tenants be kept private. Some housing authorities place information in sealed envelopes in a tenant's file to ensure confidentiality. However, it was acknowledged that fear of disclosure has a significant impact on people in need of services.

~

"There are many people who will not get tested or ask for assistance until they are ill."

Case Manager

~

Overall, **key stakeholders believed that no HIV-dedicated housing should be developed**. Suggestions included creating a listing of HIV-friendly landlords and securing set-asides in other housing programs for people living with HIV/AIDS. The Nebraska Chapter of the National Association of Housing and Redevelopment Officials (NAHRO) invited the Nebraska AIDS Project to conduct training on HIV/AIDS at a statewide meeting in September.

Across rural areas, small towns, and urban centers, transportation barriers permeate every aspect of service delivery and access to housing.

Key stakeholders spoke often about the **great distances people must travel for services and support** and the significant need for transportation assistance for people living with HIV/AIDS. In North Platte, for example, the nearest dentist who will treat people living with HIV/AIDS is 100 miles away. Outpatient clinics and infectious disease doctors do not have their own practices in smaller communities. No mental health services are available in O'Neill, which means that people must travel 75 miles to Norfolk for counseling. Service providers in many parts of the state, including HIV/AIDS case managers, experience challenges when planning and delivering services to people in multiple counties.

Even for people who live **in Omaha and Lincoln, public transportation is limited, at best**. Appropriate affordable housing is generally not located on bus lines and other forms of transportation are in short supply. Transportation support is available in Omaha for people living with HIV/AIDS to go to medical appointments and other service-related needs, but not for employment, support groups, or grocery shopping.

Funding for important support services, such as mental health and substance use treatment, is in jeopardy as the state legislature contemplates significant budget cuts.

The **availability and funding of services** were also of concern to key stakeholders. Like many states, Nebraska is facing a significant budget gap. Stakeholders anticipate decreased funding for Medicaid, even further stretching systems that are struggling to accommodate people in need. People relying on public systems and funding for necessary medications, including people living with HIV/AIDS and those with mental health issues, may experience limitations in coverage. For

people without Medicaid, access to health care and assisted living support is nearly nonexistent. Budget cuts could further reduce access to medication and services. Food banks are frequently out of food and often have varying schedules. One stakeholder explained that Temporary Assistance to Needy Families (TANF) job training programs for single female heads of households are full, and TANF rates have not been updated, leaving many families without access to needed resources.

While key stakeholders felt there are **few providers for mental health services**, they agreed there are **fewer still for substance use**, particularly for individuals without health insurance. The small community of mental health providers has decreased, and waiting lists can be long—up to two years according to a provider in Scottsbluff. Limited shelter resources for individuals currently using substances are available (one program in Omaha), and very limited detox services exist in any part of the state. In rural areas, people have to travel to larger communities for substance use treatment. Mental health and substance use impact an individual's ability to follow through with housing authority program requirements, which might mean that subsidized housing is unavailable to them.

Increased collaboration and partnerships are needed among housing and service providers to ensure that stronger, more effective community networks are available to serve people living with HIV/AIDS throughout Nebraska.

Stakeholders in every region identified the strengths of **collaboration among local agencies**. At the same time, however, stakeholders indicated that connections between housing agencies and service providers could be strengthened; in many regions, increased knowledge about the related systems was needed. Different state departments administer federal funding for housing and services, and this impacts the ability of local communities to integrate services and effectively plan to address a range of related issues.

Key stakeholders expressed a real interest in issues related to HIV/AIDS housing and **many expressed a desire to be part of housing solutions in their communities**. One key stakeholder talked about exploring options for using project-based Section 8 vouchers for transitional housing units that could serve people living with HIV/AIDS. This would involve collaboration between a housing authority and the Nebraska AIDS Project to help ensure stability for residents and consistency in keeping units filled.

A Lincoln provider described the desire for a "one-stop" model of service delivery where an array of services would be housed at the same location. Stakeholders in small communities felt that collaboration is better in rural areas, out of necessity, because there are so few providers covering a large geographical area. One provider in Norfolk described feeling left out because more resources go to providers in Omaha. This stakeholder suggested that providers establish communication networks and supportive connections. Key stakeholders were interested in receiving, through the HIV/AIDS housing needs assessment process, data relevant to their communities that would enhance local understanding of housing needs.

Staff development is another component necessary to enhance existing resources for people living with HIV/AIDS. Some stakeholders indicated that while dollars and new activities may be added to a service category, staffing levels might not increase commensurately. For example, while case management responsibilities may increase, resources are not always allocated to create additional positions or develop existing staff. Staff turnover and lack of training opportunities continue to be an obstacle to efficient service delivery and building service provider knowledge of housing referral systems and program requirements. Stakeholders suggested that service providers need better

information and training about housing resources, and that the HIV/AIDS service system could benefit from the addition of a staff person focused on housing-related issues. In addition, data collection systems may not provide good information about the range of services being used by people living with HIV/AIDS in various service systems.

The growing population of immigrants in Nebraska is experiencing multiple barriers to housing and services, including documentation requirements and a lack of translation services.

A number of key stakeholders raised concerns about barriers to services and housing for immigrants in the state. For example, it is more likely that an undocumented worker is unable to work due to documentation rather than health status. Jobs that are available are mostly manual labor, in the service industry, or migrant farming, and not conducive to maintaining good health. Steering Committee members noted that there is no clear data available about the impact of HIV/AIDS among immigrant groups and that more information is needed to understand the full extent of the issue.

Undocumented immigrants face unique barriers to housing, as well as to medical care and support services. Many who apply for housing are screened out because they do not have the documentation of income that many housing assistance providers and landlords require. Medical insurance and housing programs often require documentation that a person has the appropriate legal status to live in the United States. Providers say they usually rely on homeless shelters and an individual's own support network to patch together short-term housing options for those who have few options. As such, overcrowded family housing is an issue for many undocumented immigrants, and a complicating factor for people living with HIV/AIDS as it relates to confidentiality and other issues such as substance use. Also, undocumented immigrants are less likely to complain about landlord discrimination, or are simply unwilling to apply for housing programs for fear of deportation.

~

"The main barrier for undocumented immigrants is that their primary needs may not be HIV-related."

Social Worker

~

A **lack of proficiency in English** can cause problems when completing applications and reviewing paperwork provided by landlords or service providers. Key stakeholders said many bilingual Spanish speakers are available within communities; however, African immigrants from Sudan and Somalia face significant challenges with language and a lack of translation services. Service delivery and case planning are difficult when there are significant language barriers. Steering Committee members noted that free translation services were available through Literacy Councils located across the state.

Critical Issues and Related Recommendations

The Steering Committee met on June 12, 2003, to review findings of the needs assessment and to identify issues critical to meeting the housing and related support service needs of people living with HIV/AIDS in Nebraska. At a meeting on July 8, 2003, the Steering Committee developed recommendations and strategies to address the identified critical issues. There are four categories of critical issues and recommendations:

- Stigma and discrimination seriously impact access to housing
- Lack of appropriate affordable housing options
- Access to and availability of all necessary support services
- Financial issues for people living with HIV/AIDS

Steering Committee members reviewed findings from the needs assessment, including input from service providers, people living with HIV/AIDS, and other community stakeholders. Data summarized from available sources related to housing, homelessness, HIV/AIDS, and dedicated HIV/AIDS housing resources was reviewed.

During the June 2003 Steering Committee meeting, participants worked individually and in small groups to identify relevant issues and the results were shared with the larger group. Similar concerns were merged together to arrive at a listing of unique critical issues.

The critical issues identified by the Steering Committee were later revised, reorganized, and grouped into four general categories:

- Stigma and discrimination seriously impact access to housing
- Lack of appropriate affordable housing options
- Access to and availability of all necessary support services
- Financial issues for people living with HIV/AIDS

At the July 2003 Steering Committee meeting, participants affirmed the revisions and categorizations of the critical issues and recommended strategies and actions to address the critical issues. Each critical issue identified and recommendation developed is presented below.

Stigma and Discrimination Seriously Impact Access to Housing

Critical Issues

Throughout Nebraska, people living with HIV/AIDS and their families, service providers, and the general community are impacted by fear, stigma, and discrimination related to HIV and a lack of accurate knowledge about the disease. These issues can directly impact access to housing and feelings of housing stability. They were raised in every consumer focus group and most key stakeholder interviews. Many survey respondents and focus group participants feared losing their housing if they disclosed their HIV status to their landlord or mortgage holder. People living with

HIV/AIDS and service providers related incidents of violence and discrimination experienced by people simply because they were living with HIV/AIDS. Steering Committee members identified five specific issues that are related to this topic:

- People living with HIV/AIDS in Nebraska are impacted significantly by **HIV-related stigma**. The fear of being stigmatized affects individuals' willingness to access needed services.
- There is a lack of understanding on the part of some service providers of the need for and importance of **confidentiality** related to HIV and the impact that fear of disclosure has on the willingness of people living with HIV/AIDS to access services for which they may be eligible.
- **Fear of HIV/AIDS** on the part of service providers and community members impacts the ability of people living with the disease to access jobs, housing, and services.
- The **lack of community education** about HIV/AIDS impacts the acceptance of people living with the disease.
- Gay, lesbian, bisexual, and transgender Nebraskans experience stigma and discrimination based on their **sexual orientation**, regardless of their HIV status. As a result, Nebraskans living with HIV disease who are or are perceived to be gay, lesbian, bisexual, or transgender may experience heightened stigma and discrimination.

Recommended Strategies

The following strategies were developed to address the critical issues related to stigma and discrimination:

1. Educate community stakeholders about HIV disease and the impact of HIV/AIDS in Nebraska in order to increase awareness and acceptance of people living with HIV/AIDS and to dispel myths about HIV/AIDS and Nebraskans who live with the disease.
    - Community stakeholders to be targeted for education efforts include: the general public and community groups; policy makers and politicians; housing authorities, property managers, and landlords; support service providers, including health-care providers and employment/job training programs; and populations living with and at risk for the disease.
    - Strategies that will support education include the following:
        - Humanize people living with the disease through the sharing of personal stories and experiences. Clearly articulate the range of people affected by HIV (race, age, class, sexual orientation, etc.). Make information available through public service announcements, Web sites, public speaking, etc.
        - Build on existing relationships to increase awareness and support. For example, engage a knowledgeable and benevolent landlord, service provider, pastor, or other community member in community education efforts.
        - Support state and local leaders who include people living with HIV/AIDS, as appropriate, in their public comments, and work to increase public support for such inclusion.
        - Continue and enhance existing HIV prevention efforts. Continue to engage faith-based organizations in these efforts.

2. Increase housing stability and access to housing resources for people living with HIV/AIDS by educating them about fair housing laws and the standard operating procedures of housing authorities as they relate to confidentiality and the disclosure of disability status. Explore and develop strategies to ensure people living with HIV/AIDS have the information they need about their housing rights in order to avoid experiences of discrimination in housing.

Lack of Appropriate Affordable Housing Options

Critical Issues

More than one-third of people who completed the housing survey were at risk of homelessness because of their housing cost burden. The lack of appropriate affordable housing is clearly a very significant issue in Nebraska and is the primary housing barrier for all people with low incomes, including those living with HIV/AIDS. People living with HIV/AIDS and key stakeholders who participated in the needs assessment identified challenges in locating housing that was of a decent quality, convenient, and affordable to consumers given their incomes. More than a quarter had accessed financial assistance in the past to prevent homelessness. Steering Committee members identified four specific issues that are related to this topic:

- There is a **lack of affordable, safe, decent, and appropriate housing** that limits access to the full continuum of housing options for people living with HIV/AIDS.
- There is **limited funding** available to support the creation and maintenance of needed programs.
- Housing providers and HIV/AIDS service providers need to increase **collaboration**.
- People living with HIV/AIDS and service providers need **more information** about and awareness of available housing options.

Recommended Strategies

In order to address the critical issues related to the lack of affordable housing, the following strategies were developed:

1. Increase affordable housing units accessible to people living with HIV/AIDS. Strategies that will support increased access include the following:
    - Develop and enhance partnerships between HIV/AIDS service providers and affordable and special needs housing providers.
    - Ensure the needs of people living with HIV/AIDS are represented in housing and service planning processes, including local Continuum of Care planning for homeless services and Consolidated Plan processes.
    - Apply for all additional federal, state, local, and private resources that will support the implementation of affordable housing strategies identified in the plan or subsequently developed to address emerging need.
    - Advocate to governmental entities at the federal, state, and local levels for political support and funding for affordable housing development.

2. Increase opportunities for emergency housing solutions generally, and improve access to assistance for persons living with HIV/AIDS. Strategies that will support improved access include the following:
   - Increase linkages between AIDS service providers and emergency assistance programs.
   - Educate people living with HIV/AIDS about existing programs.
   - Develop additional target resources, if needed.

3. Increase housing stability and access to housing resources for people living with HIV/AIDS through education. Support success in housing by providing education and training about:
   - Available housing options and opportunities and how to access them
   - Tenant rights and responsibilities and fair housing laws
   - Housing search strategies
   - Life-skills development
   - Money management, budgeting, and credit repair
   - Housing readiness
   - Relapse-prevention strategies

4. Develop a comprehensive listing of HIV/AIDS services available in Nebraska, including eligibility criteria and contact information. Increase awareness of programs and guidelines by widely distributing this listing to housing and service providers throughout the state. Make the material available in forms and locations such that people could access relevant information without disclosing their HIV status.

Access to and Availability of All Necessary Support Services

Critical Issues

Access to appropriate services supports housing stability. Housing alone will not ensure health, stability, and quality of life for people living with HIV/AIDS without access to a range of medical and support services. The affordability of available resources is also an important consideration. For example, an individual who is eligible for assistance through the Medicaid program may not be able to afford the required co-pay for prescriptions. Steering Committee members identified six specific issues that are related to this topic:

- The housing and related service needs of people living with HIV/AIDS have **changed and expanded** as people are living longer with the disease.
- It is challenging to meet the needs of **an increasingly diverse population** of people living with HIV/AIDS. Specific barriers to accessing services included: language, cultural differences based on race and ethnicity, and the lack of cultural diversity among providers of HIV-related services.
- Not all clients understand **the role of case managers** and that through accessing case management support their needs are more likely to be anticipated and met to avoid crisis.
- **Linkages** between housing and all necessary support services are lacking for many people living with HIV/AIDS, including both those in need of housing and those who are housed.

- There is a **lack of transportation options** for people in both urban and rural areas of the state.
- A lack of **medical, dental, and case management services** to adequately address the global needs of persons living with HIV/AIDS was identified.

Recommended Strategies

The following strategies were developed to address the critical issues related to access to and the availability of all necessary support services:

1. Educate people living with HIV/AIDS about the services available both through the HIV/AIDS service system and the other service systems in the state.

2. Advocate for additional case management services for people living with HIV/AIDS in order to increase the support available to each client through this system.

3. Explore opportunities to develop a comprehensive peer-to-peer mentoring program to assist people living with HIV/AIDS to access housing and services and to provide peer support to those living with the disease.

4. Increase resources available to people living with HIV/AIDS who have mental health and/or substance use issues by maintaining and enhancing linkages between AIDS service providers and mental health and substance use treatment providers.

5. Increase access to appropriate services for people who are monolingual (in a language other than English) by ensuring the availability of translated materials and access to translators. Increase volunteerism among people who are bilingual. Maintain and enhance linkages between AIDS service providers and agencies currently serving monolingual populations.

6. Develop additional transportation options in order to increase access to medical and support services for people living with HIV/AIDS.

7. Increase the availability of support services to people living in rural areas of the state.

Financial Issues for People Living with HIV/AIDS

Critical Issues

Many people living with HIV/AIDS survive on very limited incomes and struggle to meet their daily financial obligations. More than a quarter of survey respondents reported incomes well below the poverty level. Steering Committee members identified three specific issues that are related to this topic:

- Due to the physical challenges faced by people living with HIV/AIDS and the inability of many to maintain employment, **poverty** is a significant barrier to obtaining and maintaining adequate housing and accessing needed services and information.
- Some people living with HIV/AIDS have high medical expenses, which impacts their financial situation and credit rating and subsequently **limits their access** to certain housing options.

- People living with HIV/AIDS and service providers need **more information about and awareness of** training and employment opportunities available to disabled persons.

Recommended Strategy

The following strategy was developed to address the critical issues related to financial issues for people living with HIV/AIDS:

1. Enhance economic opportunities for persons living with HIV/AIDS to support housing stability. Develop and enhance linkages between AIDS service providers and employment and job training programs in Nebraska, including Vocational Rehabilitation, Workforce Development, and the Ticket to Work program.

Implementation Principles and Preliminary Action Steps

"I've learned that we do have friends who are actually strangers."

Person living with HIV/AIDS in Nebraska,
commenting on his experience as a participant in
the Nebraska HIV/AIDS housing planning process

The *Nebraska HIV/AIDS Housing Plan* is the culmination of a nine-month planning process that brought together a wide range of community stakeholders to consider and plan for the housing needs of Nebraskans living with HIV/AIDS and their families. This planning process is intended to be the foundation for ongoing assessment, planning, and relationship building, and for the development of new initiatives to meet current and future need.

Overarching Principles for Plan Implementation

Implementation of the recommendations of the *Nebraska HIV/AIDS Housing Plan* is an ongoing process that requires significant community effort. The Steering Committee identified several overarching principles that apply generally to the effective implementation of the plan's recommendations.

Leadership for plan implementation: There is no doubt that implementation of these strategies relies on leadership from and the participation of a broad range of community stakeholders. The goal is that leadership will continue to emerge from a diverse group of community stakeholders in order to make the best use of existing expertise and community resources. Initial responsibility to implement the plan's recommendations will rest with the Nebraska Department of Health and Human Services and the Nebraska AIDS Project; these two agencies historically have taken the lead on HIV/AIDS housing issues in Nebraska. Ultimate leadership will hopefully come to rest in a collaboration of housing and support service experts and/or agencies.

Collaborate and coordinate: Implementation of the identified recommendations and strategies is best accomplished when, to the extent possible, efforts are coordinated to avoid duplication of work between HIV/AIDS providers and advocates and that of other community groups and committees.

Communicate regularly about HIV/AIDS housing issues: Regular communication about issues that impact the housing needs of and resources available to people living with HIV/AIDS is an important component of plan implementation. In January 2004, the Nebraska Department of Health and Human Services will initiate communication with Steering Committee meeting attendees about progress on plan implementation and to share any other relevant information. Communication will happen at a minimum quarterly; the goal is that responsibility for this communication will be shared among a number of agencies and groups.

Meet annually to review and update the plan: The goal of ongoing assessment, evaluation, and action planning is to ensure that people living with HIV/AIDS achieve greater access to housing resources and housing stability. Meetings of a broad group of interested community members and advocates will be held as necessary, and at a minimum annually. Progress on the implementation of the plan's recommendations will be assessed, and emerging issues and needs will be discussed and evaluated. Additional action steps will be developed as needed to address both existing and new recommendations. Action plans should include measurable goals and be evaluated annually.

Convene work groups when needed: It will be necessary at times to convene work groups to address certain recommendations or issues that arise. Specific activities and timelines for each work group will be developed.

Consumer advocacy: The participation of people living with HIV/AIDS in advocacy and planning efforts is essential. Advocacy efforts are most effective when consumer advocates and providers work hand-in-hand to address issues of concern. A need for education and training for consumer advocates was identified. Nebraska Red Ribbon Committee and Nebraska AIDS Project will work together to identify resources to provide initial and ongoing training to people living with HIV/AIDS on effective advocacy strategies. The population of people living with HIV/AIDS in Nebraska is diverse, and people have a range of interests and skills related to community advocacy. Steering Committee members believe that mechanisms must be developed to ensure that all people living with HIV/AIDS who are interested in participating in advocacy have a forum through which to do so.

Implementing *Nebraska HIV/AIDS Housing Plan* Recommendations

The implementation of the recommendations from the *Nebraska HIV/AIDS Housing Plan* is inter-related with both ongoing and new activities and the potential addition of new resources. This planning process increased awareness among housing and service providers about the housing-related needs of people living with HIV/AIDS and provided a forum for information sharing and relationship building. The participation of people living with HIV/AIDS and advocates in other relevant community planning processes will familiarize a broader cross section of decision-makers, service providers, and community members with the needs of this population, and will both increase awareness and decrease the divisions that lead to stigma. As needed, new initiatives will be implemented to address this key issue.

In June 2003, the Nebraska Department of Health and Human Services and community partners submitted an application for Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) funding. The community is hopeful that the application will be successful and that HOPWA funds will be available to support a range of initiatives that will increase access to affordable housing and related services, support housing stability, and, ultimately, enhance quality of life for people living with HIV/AIDS. As needed, additional planning will be conducted and funding applications submitted to support AIDS housing initiatives.

Recommendations were developed to address issues related to stigma and discrimination, the lack of affordable housing, access to necessary support services, and financial stability of people living with HIV/AIDS. The implementation of each of these recommendations is an important component to effectively meeting the housing needs of Nebraskans living with HIV/AIDS. Action plans will be developed to implement each recommendation; preliminary action plans targeting two important issues are presented here.

Preliminary Action Steps

In addition to the guiding principles that have relevance to the implementation of a broad range of recommendations and strategies, the Steering Committee chose aspects of two recommendations addressing the lack of affordable housing for which specific action steps would be developed at this time.

Affordable Housing and Homeless Services Planning

One plan recommendation (#1, page 53) aims to increase affordable housing units accessible to people living with HIV/AIDS through partnership, planning, increased funding, and advocacy. The Steering Committee focused on the planning aspect of the recommendation, which identified the need for HIV/AIDS providers and advocates to participate in housing and service planning processes. Specific action steps include:

- Seek the appointment of a representative from the HIV/AIDS community, preferably a person living with HIV/AIDS, to the Nebraska Commission on Housing and Homelessness. The Commission is a statewide advisory committee that provides input to the governor, the Nebraska Department of Economic Development, and other community leaders on a range of policy and program issues related to affordable housing and homelessness.

  Objective: To ensure the voices of people living with HIV/AIDS are represented and to expand opportunities for directed funding.

- Continue participation by HIV/AIDS advocates on the Continuum of Care Committee, a sub-committee of the Nebraska Commission on Housing and Homelessness. Currently, representatives from the Nebraska AIDS Project and the Nebraska Department of Health and Human Services participate in the Continuum of Care Committee.

  Objective: To ensure that the housing and related service needs of people living with HIV/AIDS are articulated locally and to build collaboration with housing and support service agencies.

- Develop knowledge about the range of community planning activities and information sharing forums that are relevant to the housing needs of people living with HIV/AIDS, including local Consolidated Plan and Continuum of Care processes. Prioritize these forums for participation by service providers and people living with HIV/AIDS.

  Objective: To ensure the needs of the people living with HIV/AIDS are comprehensively represented in relevant community planning efforts.

- Implement effective methods to disseminate information from these community-planning forums to the wider HIV/AIDS community.

  Objective: To ensure that service and support agencies and people living with HIV/AIDS are informed about and understand the relevance of affordable housing and service planning issues.

Housing Stability

One plan recommendation (#3, page 54) aims to increase housing stability and access to housing resources for people living with HIV/AIDS through education and training on a variety of topics. The Nebraska AIDS Project provides a range of support services to people living with HIV/AIDS, including case management, and works to connect consumers to all relevant services and resources in the wider community. The Nebraska AIDS Project will take the lead on implementing this recommendation. The Steering Committee identified initial action steps:

- Develop knowledge about providers of and available resources for life skills, fair housing, landlord-tenant, and other relevant trainings that will promote housing stability for people living with HIV/AIDS.

  Objective: To develop a broad, strong training and education resource base.

- Strengthen and develop additional linkages with community-based agencies providing relevant trainings and education programs to people living with HIV/AIDS. As necessary, provide information and support to these programs to help ensure that they have the necessary depth of knowledge about the needs of people living with HIV/AIDS.

  Objective: To ensure that people living with HIV/AIDS have access to appropriate community training and education resources to assist in building self-sufficiency skills.

- Develop education or training programs that specifically target people living with HIV/AIDS if necessary.

  Objective: To ensure that needed training and education programs are available to people living with HIV/AIDS by filling identified gaps.

Ongoing and Future Initiatives

The Nebraska HIV/AIDS housing needs assessment and planning process increased connections among people across the state and provided a deeper understanding of the housing needs of people living with HIV/AIDS. The implementation principles and action steps presented here represent only one of the next steps in this ongoing process. The implementation of effective initiatives and programs relies on increased community knowledge, successful partnerships, and continued assessment and planning. The stakeholders involved in this process have an ongoing commitment to addressing all the identified needs through further action planning, increased collaboration, and securing new sources of funding to support programs.